FRCH RESEARCH REPORT:1

# NGOs IN RURAL HEALTH CARE

## VOLUME ONE: AN OVERVIEW

(SPONSORED BY THE INDIAN COUNCIL OF MEDICAL RESEARCH)

AMAR JESANI MANISHA GUPTE RAVI DUGGAL

MARCH 1986

THE FOUNDATION FOR RESEARCH IN COMMUNITY HEALTH

84-A, R.G.THADANI MARG, WORLI, BOMBAY 400 018.

FRCH RESEARCH REPORT : 1

# NGOs IN RURAL HEALTH CARE

## VOLUME ONE : AN OVERVIEW

(SPONSORED BY THE INDIAN COUNCIL OF MEDICAL RESEARCH)

AMAR JESANI MANISHA GUPTE RAVI DUGGAL

MARCH 1986

THE FOUNDATION FOR RESEARCH IN COMMUNITY HEALTH
84-A, R.G.THADANI MARG, WORLI, BOMBAY 400 018.

| | | |
|---|---|---|
| **Secretarial Assistance** | : | **amirbanu sumnani** |
| | | **benaifer mehta** |
| | | **meher edibam** |
| | | **shashikant more** |
| | | **thomas zachariah** |
| **Statistical Assistance** | : | **sunil manapure** |
| **Artwork** | : | **madhu rokle** |

## ACKNOWLEDGEMENTS

We are sincerely grateful to the Indian Council of Medical Research, especially Prof. Ramlingaswami, for not only funding the study but also for being patient with us for the delay in the start of the study (due to recruitment of suitable investigators). The study was originally sanctioned in early 1981 and officially commenced in mid-1982 but fully got off the ground only in early 1983. As a consequence the ICMR thankfully granted a nine-month extension.

Before we commenced the study we met a number of "experts" in the field of health and development to discuss the issues involved in the study and to evolve the focus and the final study design. Limitation of space prevents us from listing everyone but we express our thanks to each one of them. Special gratitude is due to Prof. Ashish Bose, Prof. P.B. Desai and their research team at IEG, Mr. Harcharan Singh (Planning Commission), Dr. Debabar Banerji (JNU), Dr. Asha Bhende and Ms. Tara Kanitkar from IIPS, and our friends with whom we discussed about the study at great length. Thanks are also due to Mr. J.C. Sharma and Mr. Salvi of the TISS computer department for helping us with the computer processing. We are thankful to Mr. Srinivasan (former health secretary of Maharashtra), the staff of the Directorate of Health Services - Pune, staff of the Rural Development Ministry - Bombay and the Charity Commissioner, Bombay for giving us the data that we requested of them. And ofcourse, we are sincerely grateful to all the NGO project-holders and their staff without whose sustained willingness to participate in the study we could not have ventured to undertake this research endeavour.

Special thanks to Ms. Annie George for proof-reading the final manuscript and to our secretarial staff who shared the brunt of our several 'final' drafts. And last but not the least our most earnest gratitude to Dr. N.H. Antia who went through our drafts critically, devoted a great deal of his time to discuss them and provided continuous encouragement and support for carrying out the study.

## LIST OF ABBREVIATIONS USED

| | | |
|---|---|---|
| AFARM | : | Action for Agricultural Renewal in Maharashtra |
| AFPRO | : | Action for Food Production |
| AIWC | : | All India Womens' Conference |
| ANC | : | Ante-natal Care |
| ANM | : | Auxiliary Nurse Midwife |
| AVARD | : | Association for Voluntary Agency in Rural Development |
| BAMS | : | Bachelor of Ayurvedic Medicine and Surgery |
| CAFI | : | Chemicals & Fibres India |
| CARE | : | Committee for Americal Relief Everywhere |
| CASA | : | Church Auxiliary for Social Action |
| CBHI | : | Central Bureau of Health Intelligence |
| CDP | : | Community Development Project |
| CED | : | Centre for Education and Documentation |
| CEO | : | Chief Executive Officer |
| CHG | : | Community Health Guide |
| CHW | : | Community Health Worker |
| CHV | : | Community Health Volunteer |
| CMAI | : | Christian Medical Association of India |
| CMC | : | Christian Medical Commission |
| CMIE | : | Centre for Monitoring Indian Economy |
| DANIDA | : | Danish International Development Agency |
| DEL | : | Delivery |
| DHO | : | District Health Officer |
| DPAP | : | Drought Prone Area Programme |
| DW | : | Deutsch Welthungarchilfe |
| EGS | : | Employment Guarantee Scheme |
| EZE | : | Evangelische Zentralstelle Fuer Entwicklungshilfe EV (same as PCADA) |
| FFW | : | Food for Work |
| FP | : | Family Planning |
| FPAI | : | Family Planning Association of India |
| FRCH | : | Foundation for Research in Community Health |
| FWRTC | : | Family Welfare Rural Training Centre |
| GMC | : | Grant Medical College |
| GMLF | : | Gandhi Memorial Leprosy Foundation |
| GOI | : | Government of India |
| GOM | : | Government of Maharashtra |
| HCD | : | Health Care Delivery |
| HCDS | : | Health Care Delivery System |
| ICCW | : | Indian Council for Child Welfare |
| ICMR | : | Indian Council of Medical Research |
| ICSSR | : | Indian Council of Social Science Research |
| IEL | : | Indian Explosives Limited |
| IGSSS | : | Indo-German Social Service Society |
| IMA | : | Indian Medical Association |
| IRDP | | Integrated Rural Development Programme |
| KEM | : | Kind Edward Memorial |
| KVIC | : | Khadi and Village Industries Co-operative |
| MCH | : | Maternal and Child Health |
| MFAL | : | Marginal Farmers and Agricultural Labourers Agency |
| MHFW | : | Ministry of Health and Family Welfare |
| MPH | : | Masters in Public Health |
| MPHW | : | Multi-purpose Health Worker |
| MPW | : | Multi-purpose Worker |
| NGO | : | Non-Government Organisation |
| NIPCCD | : | National Institute for Public Co-operation and Child Development |
| NREP | : | National Rural Employment Programme |
| NSS | : | National Social Service Scheme |
| OPD | : | Out Patient Department |
| CMO | : | Chief Medical Officer |
| PCADA | : | Protestant Central Agency for Development Aid |
| PHC | : | Primary Health Centre |
| PHN | : | Public Health Nurse |
| PHU | : | Primary Health Unit |
| PNC | : | Post-natal Care |
| PRIA | : | Society for Participatory Research in Asia |
| PSM | : | Preventive and Social Medicine |
| PTSW | : | Part-time Social Worker |
| RSS | : | Rashtriya Swayam Sevak Sangh |
| SET | : | Survey Education and Treatment |
| SFDA | : | Small Farmers Development Agency |
| SIDA | : | Swedish International Development Agency |
| TDH | : | Terre Des Hommes |
| TISCO | : | Tata Iron and Steel Company |
| TISS | : | Tata Institute for Social Sciences |
| TRYSEM | : | Training Rural Youth for Self-Employment |
| 3 R Society | : | Research Rehabilitation and Reconstruction Society |
| UNICEFF | : | United Nations International Children's Fund |
| USAID | : | United States Agency for International Development |
| VHAI | : | Voluntary Health Association of India |
| VHW | : | Village Health Worker |
| WCC | : | World Council of Churches |
| WHO | : | World Health Organisation |
| YMCA | : | Young Men's Christian Association |
| ZP | : | Zilla Parishad |

## FOREWORD

The past four decades have demonstrated the difficulty which the government encounters in reaching health services to our people, the majority of whom live in the half-a-million villages or in the proliferating slums of our cities.

This is an area where Non-Government Organisations (NGOs) have considerable advantage over the public as well as the private health sector because of their motivation and sympathy for the deprived sections of our society and their personalised approach to this problem.

The ICMR/ICSSR Report "Health for All: An Alternative Strategy" emphasised the importance of involving NGOs in the task of national reconstruction, especially in the field of health. It is to the credit of our Government that this has been reiterated in the National Health Policy. The past few years have seen a continuous dialogue between the NGOs and the Ministry of Health as well as the Planning Commission. These dialogues have been at the highest level including at that of the Prime Minister. This demonstrates the importance that our Government places in involving the NGOs in our national health programmes at the stage of planning as well as implementation. Unfortunately when it comes to collaboration at the district and village level, it still leaves much to be desired.

The present study was undertaken by the Foundation for Research in Community Health (FRCH) at the behest of the Indian Council of Medical Research (ICMR) to gain a deeper insight into the role and functioning of the many different types of NGOs in the field of health located in Maharashtra, a state having the largest number of such agencies. The FRCH, which provided the secretariat for the ICMR/ICSSR Report "Health for All-An Alternative Strategy", has undertaken the present study over the past three years.

Report of this project has been divided into two parts. The first part, which is reported in this volume, consists of a study of a large number of NGOs whose sole or major activity is in the field of health. It has not been possible to cover all the NGOs of Maharashtra but we feel that the majority of the important ones have been covered. This study has deliberately refrained from covering the NGOs working in urban areas and the NGOs who are run for profit.

This study brings out the large invariation between the aims and motivation of the various NGOs as well as their different approaches which vary from the running of rural hospitals to community participation and conscientisation. It also brings out the change of approach of the NGOs during the past two decades from being mere medical functionaries to involvement in community activities.

An interesting finding of this study is that the NGOs have hitherto neglected socially and economically backward districts as compared to their better concentration in the average and highly developed districts in the state of Maharashtra. This highlights the need to pay more attention to the deprived masses in the backward districts where infrastructure is highly underdeveloped.

In fact this is a challenge for the NGOs and we hope they will fulfill this need by orienting them to the backward districts.

Although this study analyses various characteristics of the NGOs at great length, some of its limitations should be kept in mind for the better appreciation of the information presented in this volume. This study is not a treatise on voluntarism and the NGO sector. A need for a comprehensive theoretical and factual macro-analysis of the NGO sector in Indian economy is increasingly felt by the

researchers and planners alike. This study, however, did not aim to produce such a document. The comments on the concept of voluntarism and community participation are largely based on the researchers' observation made while visiting twenty one projects. In fact they are made to raise some pertinent questions on these often loosely used terminologies and also to put the findings of this study in perspective.

Another feature of this study is that no hasty conclusions are drawn from the findings presented in this volume. The researchers have thought it prudent to wait till the analysis of the four case studies is completed. And therefore the detailed analysis of success and failures of NGO programmes as compared to those of the government, and the final conclusions and guidelines for the NGOs, constitute subject matter for the second part of this study.

I wish to thank all the NGOs and many other people for extending their cooperation in providing the relevant information to our investigators. Finally, we feel that this volume will be of help not only to the NGOs running field projects but also to those who wish to start or support new NGOs and concerned researchers by providing some additional material to critically understand the role and relevance of the NGO sector in Indian society.

N.H. Antia

10th March, 1986

BOMBAY

DR. N.H. ANTIA

# CONTENTS

## PART - I : INTRODUCTION

Non-Government organisations (NGOs) over the years have become an important segment of the development and welfare sectors. A large number of NGOs are working all over the country, each with its own approach, methodology and objective.

In the last two decades proliferation of NGOs, or what are popularly called "voluntary organisations", has been very rapid in rural India. Although such proliferation has also taken place in urban areas, the NGOs in rural areas have come to occupy an important place in the governments' development strategy and hence have attracted more attention at the national level.

NGOs in the field of health care have acquired a considerable importance since the emergence of the "community health approach". Successful experiments in Maharashtra with the community health model in the first half of the seventies and the subsequent official support to it extended by the government of India in 1977 and the WHO in 1978, have been largely responsible for rapid multiplication and involvement of NGOs with community health care programmes in rural areas. Also liberal financial assistance, especially from international agencies, private, bilateral and multilateral, have encouraged a large number of NGOs to jump on the bandwagon of "Health for All by the year 2000".

In this part of the volume we shall define NGOs and trace briefly their evolution in India, especially with regard to government policy making.

## 1. DEFINING NGOs

Non-governmental organisations generally speaking would include the entire private sector. But in its popular usage the term NGO is not the equivalent of the popular notion of the private sector.

How is it different from the private sector and what are its features ?

### What are NGOs ?

NGO and "voluntary organisations" are most often used as interchangeable terms. But such usage is incorrect because strictly speaking such organisations are neither voluntary in character nor are individuals working in them volunteers.

NGOs are private organisations with a difference. Firstly, an overwhelming majority of NGOs are registered as **public trusts or societies.** The adjunct of this is that they can receive donations and donors of funds to such organisations are eligible for various tax deductions. Secondly, NGOs are run as **non-profit making ventures.** Thirdly, the areas of work they are involved in is what is popularly known as the **development sector.** This includes welfare programmes such as health, education, nutrition, family planning, water supply and housing; and agriculture related development programmes (IRDP etc.) and employment programmes (EGS, FFW etc.). And fourthly, NGOs as a rule do not generate their own funds completely but rely on **external financial assistance** from government agencies as well as non-government (funding) agencies, both national and international.

We may also add an additional feature of NGOs: to a large extent the programmes adopted by NGOs, especially in rural areas, are **programmes of the governments rural development and social services sector** and quite often the implementation of these programmes are considered a **collaborative effort.**

### Types of NGOs

NGOs operate both in the rural areas as well as urban areas. They may be international, national or local in character. Their purpose may range from funding (OXFAM, Action Aid, CARITAS, EZE, Ford Foundation, Aga Khan Foundation, AVARD, Jamsetji Tata Trust etc.), to providing services (NGO projects in our sample), research and documentation (FRCH, PRIA, CED, etc..) and other such programmes. Any of the above may have a variety of vested interests and may have a range of affiliations, including political, religious and corporate.

In the present study our concern is with the local NGOs who operate field projects in rural areas. These NGOs may be independent agencies or may be part of a larger body.

Finally, it must be emphasised that in recent years, mainly since the Sixth Five Year Plan, the role of NGOs in development programmes has become a kind of "official work" because they are doing the task that the government has been unable to fulfil, as promised, after our Independence and with the beginning of the first Five Year Plan. The following quote from a recent government document ("Collaboration with NGOs in Implementing the National Strategy for Health For All", Ministry of Health and Family Welfare, GOI, Delhi, April 1985 pp.13-14) substantiates this role:

"Achieving active community participation and involvement in health and health related programmes should also be part of the strategy. In particular, active community participation and involvement of non-governmental organisations in a massive health education effort is urgently needed .....

with a view to reducing government expenditure and fully utilising untapped resources, planned programmes may be devised, related to the local requirements and potentials, to encourage the establishment of practice by private medical professionals increased investment by non-governmental agencies in establishing curative centres and by offering organised logistical, financial and technical support to voluntary agencies active in health field."

## 2. NGOS - A HISTORICAL PERSPECTIVE

NGO intervention amongst communities in an organised manner may be traced to **Christian missionary activity.** The missionaries approached deprived and exploited communities and offered them compassion, hope and benefits (health, education, nutrition or even economic). They were motivated workers, convinced of Christian ideals and worked sincerely with the ultimate objective of proselytisation.

In India Christian missionary work is very old but it proliferated a great deal during the British rule. It was only in the 19th century that serious **non-Christian NGOs** began to evolve. They began with the efforts of Vidayasagar and Ram Mohan Roy to bring reform within Hindu society. With the emergency of the Arya Samaj and the Rama Krishna Missions there was a reaction to Christian missionary activity, and indigenous NGOs began to evolve in India; other religious groups (Muslims and Sikhs) also emerged for organised social action to protect and develop their communities' interests. Linked to India's freedom struggle a large number of NGOs emerged in fields of wide ranging activities but only **Gandhian/Sarvodaya** organisations, besides the religious groups, may be considered of any significant consequence in the welfare sector, especially in rural areas. Until the late sixties the **charity-orientation** of religious missions and Gandhian/Sarvodaya groups was the dominant approach for most NGOs. Attitudes of piety and compassion towards the "poor and downtrodden" motivated senior citizens to work amongst such people. It was invariably an individual's mission of charity to do "constructive work" in a deprived community.

Charity linked to altruism did not remain confined to religious missions and zealous individuals but also afflicted the sensibilities of large business houses. For instance, "Tata" at the turn of the present century began charitable work among tribals, where the city of Jamshedpur stands today; by 1907 TISCO was launched and in the process appropriated the land of the tribals in several villages to build the factory and subsequently the township.

For the government of independent India the tasks of development, especially rural uplift, were tremendous. The government launched its **Community Development Programme** (CDP) in 1952. It is interesting to note that the basis for evolving the CDP were two NGO experiments, one by Albert Meyer in Etawah district of U.P., and the other by the YMCA in Martandam, Tamil Nadu. Both these models were based on earlier American experiments.

The **government recognised the role of NGOs** in the welfare sector from the very beginning. The First Five Year Plan, during which the CDP was launched, notes: "A major responsibility for organising activities in different fields of social welfare; like the welfare of women and children, social education, community organisation etc. falls naturally on private voluntary agencies. These private agencies have

long been working in their own humble way and without adequate aid for the achievement of their objectives with their own leadership, organisation and resources. Any plan for social and economic regeneration should take into account the services rendered by these agencies and the state should give them maximum co-operation in strengthening their efforts. Public co-operation through voluntary social service organisations is capable of yielding valuable results in channeling private efforts for the promotion of social welfare" (GOI Planning Commission, First Five Year Plan, 1951, p.607).

Thus in 1953 an estimated 1739 NGOs all over the country were getting 'grant-in-aid' from the govt. (Maharashtra state accounting for 20%) and by 1980 the number had increased to 8052. (N.V. Lalitha and Madhu Kohli, Status of Voluntary Effort in Social Welfare, NIPCCD, 1982).

A **change from charity-orientation** by NGOs became apparent in the mid-sixties by when the government had realised that most of its development efforts had failed miserably. The green revolution had taken the corporate sector to the countryside. The World Bank too had become supportive of anti-poverty programmes for the rural areas of the third world because widespread famine and drought conditions had generated a lot of unrest.

The strategy changed from charity to **self-reliance** and as a consequence area development programmes (SFDA, DPAP, MFAL etc.) were chalked out and were to be implemented in close collaboration with NGOs as well as with the corporate sector which was directly interested in agri-business. NGOs working in the welfare sector also moved away from the charity approach to one of a **community approach,** whereby local resources (mainly manpower) were to be used for the community's development.

It was in the health sector that this new orientation first emerged. Experiments at Narangwal (Punjab) in the late sixties showed the way but its consolidation took place in Maharashtra with Jamkhed, Mandwa/Uran, Miraj and Kasa projects leading the field.

This 'new' approach as contrasted with the charity approach has been attributed three characteristics. Firstly, it is **against giving anything free of charge;** second, it is **characterised by a project-based involvement;** and third, it is **professional in character.**

The working philosophy of this new approach thus appears to be 'not to give anything free of charge' because: (a) whatever is given free is not seen by people to have a value; (b) it creates a "feudal" relationship of giver-recipient, reinforcing "patriarchy"; (c) it generates a dependancy among beneficiaries and therefore makes the latter complacent and (d) it acts as a barrier to 'people's participation'.

In the field of health care the earlier approach was to set up a hospital or dispensary at a taluka place or a densely populated village on an accessible route, most often providing free services. But now, since the early seventies, there is an increasing trend to provide health care services at cost at the door step of consumers through village level workers. This has come to stay; and charity, as far as free-of-charge service is concerned, is on the decline. As we move through the eighties a 'struggle-orientation' appears to be the 'in-thing' for an increasing number of NGOs. This is largely a fall-out of the civil liberties movement and directed mainly towards consumer action so that the existing system becomes apparently more efficient, efficacious and accountable - the character of the struggle in no way being indicative of bringing about any radical social change.

## 3. NGOS AND GOVERNMENT POLICY MAKING

NGOs have regularly interacted with policy makers and the government since independence. Despite their negative experiences in many cases, especially in their efforts to collaborate with government functionaries at the gross-root and with the middle level bureaucracy, their efforts have very often been acknowledged and recognised in policy making at the national level, howsoever distorted and opportunistic such recognition may be. In 38 years of this interaction, NGOs and the government have tried to build rapport and understanding with each other. In this time period however, the developments in this relationship have not been linear. Some visible qualitative changes have come about in the manner in which NGOs have sought to influence government policies. Three phases of the change can be identified:

The **first phase** started from the formative years of planning until the end of the Third plan period in 1966. The latter part of this phase also coincided with the intial years of the green revolution. This is also the period in which the enthusiasm created due to national independence, and the radical utterances of the government in transforming Indian society, dominated the political scene. On the one hand, the **NGO sector in this period showed much more direct connection with the government through the political party in power;** this was partly due to the preponderance of the NGOs motivated by the Gandhian ideology and Sarvodaya, as an off-shoot of the Independance movement. On the other hand, to fulfill its promises the government needed a sort of blue-print to base its strategy of rural transformation through state intervention. This symbiosis of interest, aided by the activities of international agencies since 1930s for persuading the developing countries to accept the concept of community development, led to the beginning of a peculiar relationship between the NGOs and the government. The government acknowledged and adopted models of community development evolved by NGOs, but it did not accord any official status to them in the implementation of development programmes. The government however continued to give them grant-in-aid and left the aspects of collaboration at the level of the local bureaucracy. This was also because it was just the beginning of planning and the government appeared to be confident to carry through on its own the implementation of plans for social transformation.

Thus, in this phase the **traditional or classical ways of social work dominated in the NGO sector** and the latter placed implicit faith in governments' commitment to fulfil promises given to the people in the independence movement.

The **second phase,** which roughly covers the period of one and a half decade (mid 1960s to the later part of 1970s), is characterised by (a) the **growing disillusionment** with the idea that government can, on its own, fulfill the tasks of development, (b) proliferation of the **NGOs outside** the sphere of influence of the **Gandhian ideology**, (c) application of **innovative methods** in rural development, (d) increased interest of the **NGOs in the field of health** and (e) the **entry of business houses,** directly or through agencies sponsored by them, in response to the new opportunities opened up by the green revolution in the field of rural development. In this phase the NGO, propped up by the support they received from international agencies, business houses and religious organisations, started feeling the strength of their work. Their achievement also became more manifest with the wearing away of the euphoria of the independence movement and the broad realisation that planning has not really helped those who needed help most. Thus a section of the NGOs became more vocal in its criticism of the government machinery and they found national platform in the political turmoil of this period. Moreover, the economic liberalisation started from the mid-1970s, howsoever limited, also had an effect of giving more room to private agencies and the NGOs to operate.

In the **field of health** two developments took place : (1) the **method of using village level workers** for the delivery of primary health care, demonstrated through NGO experiments, found its supporters and ultimately led to the acceptance of it in the government policy and (2) with an **increasing number of NGOs adopting health** as a major area of their work or with health as an important component of their work in rural development, the role of NGOs in health emerged as a separate entity. Initial efforts were made to coordinate their efforts in persuading government to give them more scope in implementation of their plans. In this phase, for the first time, they started feeling that they must create their own lobby in parliament or in government circles to get their recommendations accepted.

With the beginning of the **Sixth Five Year Plan** in 1980, the **third phase** of the NGO - government relationship started. In this phase the NGOs consolidated their gains and started asserting their position. When discussions started for the formulation of the Seventh Plan, their representatives got places in government policy making bodies. Simultaneously some of their vocal representatives published articles, wrote open letters to the Prime Minister etc., and thereby stimulated a public debate on the role of NGOs in Plan implementation. The NGOs, for the first time, used all possible public platforms like news papers, journals, and other media. They also effectively asserted their position in government bodies where they were made members or consultants, persuaded higher echelons of the bureaucracy and politicians to get their views felt. The results of these efforts by the NGOs is clearly seen in some of the recent government documents. Below we reproduce some important statements :

The **Approach Paper of the Seventh Five Year Plan,** demanding greater participation from NGO's, states, "voluntary organisations will have to be associated more closely and actively than hitherto with the programmes for reduction of poverty and with their efforts to make the minimum needs available to the population for improving their quality of life. This will be incorporated as part of the overall strategy for augmenting such programmes meant for the poor, as also an alternative feedback mechanism for ascertaining whether the target groups have receive the benefits meant for them" (Planning Commission, The Approach to the Seventh Five Year Plan 1985-90, GOI, New Delhi, 1984).

The **Ministry of Health and Family Welfare** (MHFW) is in full agreement with the Planning Commission on the issue of greater involvement of NGOs in the field of Health Care. In a recently published document ("Collaboration with NGOs in Implementing the National Strategy for Health For All, GOI, New Delhi 1985) it categorically states, "The government has envisaged a very prominent role of voluntary organisations/NGOs in the implementation of these (health, family planning and 20-point) programmes. In October 1982, directives were issued that voluntary agencies be involved in the implementation of anti-poverty and minimum needs programmes which contain all the important health programmes like MCH, family planning, communicable diseases, health education, drinking water facilities, immunisation, etc., and consultative groups be formed in all the States headed by a senior officer of the State .... Voluntary organisations are doing a very creditable job in organising and running hospitals and dispensaries in India. India is only second to USA in terms of number of hospitals outside the government health sector and run by NGOs. If suitably encouraged in terms of liberal financial grants, they can contribute a great deal in filling the gap of referral hospitals at taluka level, district level and in urban slums."

Even the **National Health Policy** of 1983 recognises the need for greater reliance on the voluntary and private sectors for achieving the goals of 'Health for all by the year 2000 A.D.' **"The policy envisages a very constructive and supportive relationship between the public and private sectors in the area of health by providing a corrective to re-establish the position of the private health sector" (ibid).**

We must keep in mind that the NGO sector is not as homogenous as say the business community because in business we can easily identify a central motive, which is profit, while the central character of the NGO, has a wide variety of motives. This variety itself affects their capability of carrying out effective lobbying. Therefore, the very fact that so many NGOs could orchestrate their views, both in public as well as in government circles, and could ultimately get official recognition in policy making, is indicative of their growing strength and the qualitatively new phase that has begun in the relationship between the NGOs and government.


## NGO PROJECT LOCATION IN MAHARASHTRA AND LEVEL OF ECONOMIC DEVELOPMENT.

LEVEL OF ECONOMIC DEVELOPMENT

- ABOVE AVERAGE DISTRICTS
- AVERAGE DISTRICTS
- BELOW AVERAGE DISTRICTS

**NOTE:**

For Identification of numbers see Part IV of this report (NGO Profiles).
NGO no. 15 is not listed as it runs hospitals in a number of districts.

## PART - II : FRAMEWORK OF THE STUDY

The 'Critical Study of Health Services Projects in Maharashtra' has been conducted at two levels.

Firstly, we have evaluated 45 rural health projects run by NGOs to get an overview of the NGO sector. This has been done through both personal visits and mailed questionnaires. The present volume delineates these findings.

Secondly, we selected four NGOs, each having a different approach and mix of activities and located in regions with varying social-geographies. In each of these areas we also selected on adjacent Primary Health Centre area as a 'control'. These case-studies are presented in a separate volume.

In this part of the document we define our objectives and explain the methodology of the study.

## 4. OBJECTIVES OF THE STUDY AND ITS IMPORTANCE

The study aims at critically evaluating intervention of NGOs in rural health care, especially those using alternative models of primary health care. This study is in a sense a continuation of the 'Health For All: An Alternative Strategy', a policy document produced by a joint study group of the ICSSR and ICMR.

The ICSSR/ICMR report was formulated on the basis of experiences of various NGOs, especially from Maharashtra in delivering health care through alternative models. The recommendations of the report have largely been incorporated in the National Health Policy of 1983.

The present study sets out to evaluate the functioning of such alternative models of primary health care and the purpose they have served.

At the outset the following **objectives** for the study were identified :

1. To document the work of NGO health and development projects operating in rural Maharashtra.
2. To analytically study the objectives, organisation and functioning of NGO projects.
3. To critically evaluate the setting up, evolution and running of such projects.
4. To study the achievements and problems of selected projects, identifying factors for failure or success.
5. To make comparative assessment of selected projects with government primary health services in order to identify factors responsible for differences between them, if any, and
6. To evolve guidelines for health projects on the basis of the findings of the study.

**The present volume deals with only the first three objectives.**

### The need for such a study

The necessity for making a special effort to take health care to the underprivileged majority was recognised as early as 1946 by the **Bhore Committee.** Government policies generally chose to ignore the need because health care services by themselves lack political capital; it was assumed that a proliferation of health care facilities would in themselves be sufficient. On the other hand, a few non-government agencies, both Indian and foreign, did perceive the need for evolving health projects specifically targeted at areas in primary health care that were deficient and most urgently needed.

This has primarily meant a change in both orientation and in prioritisation of the components of health care. Every such NGO project has necessarily been an experiment in testing a variety of inputs and methods in bringing about a change in health status.

A number of health projects and schemes, many of them run by independent non-government agencies, have been established in Maharashtra. These provide us with an excellent opportunity to study the functioning of the projects and to analyse them in terms of inputs, methodology of approach and results and consequences, so that suitable guidelines for study and models for replication could be developed.

At present, while there are reports of individual projects, there has been no attempt to make a holistic and comprehensive study. We have come across some studies in this area which are somewhat

similar to the kind of study we have undertaken although the specific aims have been different.

In 1975 the **Scandinavian Institute of Asian Studies** published an extensive study of the introduction of western medicine in a Tamil village undertaken by two sociologists. Although the study covered only one village, it was aimed at demonstrating this significant thesis: that the health situation was related to the social and economic processes and that only a profound transformation of the economic and political structure can give the people the means to improve their own health.

In October 1976, a symposium on Alternative Approaches to Health Care was organised jointly by the **ICMR and ICSSR.** The proceedings of the symposium have since been published and include briefly guidelines on methodology and parameters for assessment in the field.

The **Narangwal** project's results were published in 1976 providing guidelines for analysis of project outputs and achievements. An international study by the **American Public Health Association,** published in 1977, explored 180 health projects (31 in India) in the developing countries and concluded that more detailed studies were necessary to understand the meaningfulness and feasibility of alternative low cost health projects. **David Pyle's** recent study of health projects in Maharashtra, undertaken for the Ford Foundation in 1979, has identified major factors that contribute to the success of different schemes. And in 1982 a study of 14 health, nutrition and F.P. projects in India by staff of the **World Bank** has summarised the work of these projects, highlighting the common as well as differential elements among them.

Apart from these there have been several other studies which have dealt with narrower fields or with only a few of the components of health care. The study we have undertaken encompasses the entire state of Maharashtra (rural) and attempts a comprehensive analysis both at the macro level and the micro level.

## 5. METHODOLOGY OF THE STUDY

The study has been carried out in two phases. The present volume pertains to the first phase of the study: An overview of NGOs in Maharashtra state based on information of 45 projects. This phase of the study conducted during the calender year 1983 involved a state-wide probe of NGOs having some significant health component in their projects.

**Identification of NGOs** was indeed a difficult and cumbersome task because no comprehensive list of such agencies is easily available. However, a few directories listing NGO projects engaged in various types of activities helped us in getting off the ground. Lists with abstracts prepared by Voluntary Health Association of India (VHAI), Association for Voluntary Agencies in Rural Development (AVARD), National Institute of Public Cooperation and Child Development (NIPCCD) and the Ministry of Rural Development - Government of Maharashtra (GOM), were useful in identifying NGOs and their projects. Also, our own informal contacts and channels of information helped in adding to the published lists.

Scanning of the brief abstracts in these lists and with the aid of our informal sources we finally **short-listed 118 NGOs** that appeared to be involved in significant community oriented health care services. This shortlisting are based on the following criteria :

i) projects must be rural; and

ii) projects must have community oriented health programmes.

These 118 NGOs were sent a short list of **open-ended queries** with a covering letter informing them about the objectives of the study, asking for a brief description of their projects (see Appendix 'C' for a list of NGOs identified by us). Fifty-eight projects (or 49%) responded - ranging from courtesy responses and scanty information to detailed reports and evaluation studies (Figure 1).

Subsequently, over a period of almost a year, we **visited 23 NGOs** spread all over the state to get a first hand account of what was happening in the field. At each project we spent three to five days visiting their field sites, and had informal discussions both with their staff as well as groups of beneficiaries.

The **objectives of these visits** was to :

(a) orient ourselves to the wide-array of projects and their differing approaches, organisation and functioning;

(b) to have discussions with their staff and some of their beneficiaries so that we may acquire a better understanding, especially qualitative, of the projects;

(c) to obtain information that would not be possible through questionnaires, like socio-political implications, socio-economic settings, etc.; and

(d) to prepare the ground for the subsequent micro study.

Besides visiting these projects we sent a **structured questionnaire** (see Appendix 'D') to all the 58 NGOs who had responded and got adequate information on 45 NGO projects that have been included in the present study. There still remained gaps in the information which we, wherever available, supplemented through other published sources, data collected on our visits to projects, and through further correspondence.

We next prepared detailed **profiles of 45 NGOs** (ofcourse, in the meantime we had begun the micro-study - see Volume II) and sent them to the respective NGOs for verification, correction and filling in gaps of information. To assure their response we made a few provocative statements to which we were positive the project-holders would respond; an overwhelming majority did respond but some information gaps, especially those pertaining to finances, still remained. These NGO project profiles (Part IV) only form an information base. They do not contain any critical analysis or our personal observations.

It must be noted here that, as far as we know, all **community health projects** in Maharashtra (established upto 1983) have been identified and covered by us. Also, NGO projects that have been terminated are included in the study. Two of the terminated projects are not strictly NGO projects but government pilot projects with some technical and managerial inputs from NGOs. Three of the six terminated projects in our sample folded up during our study period.

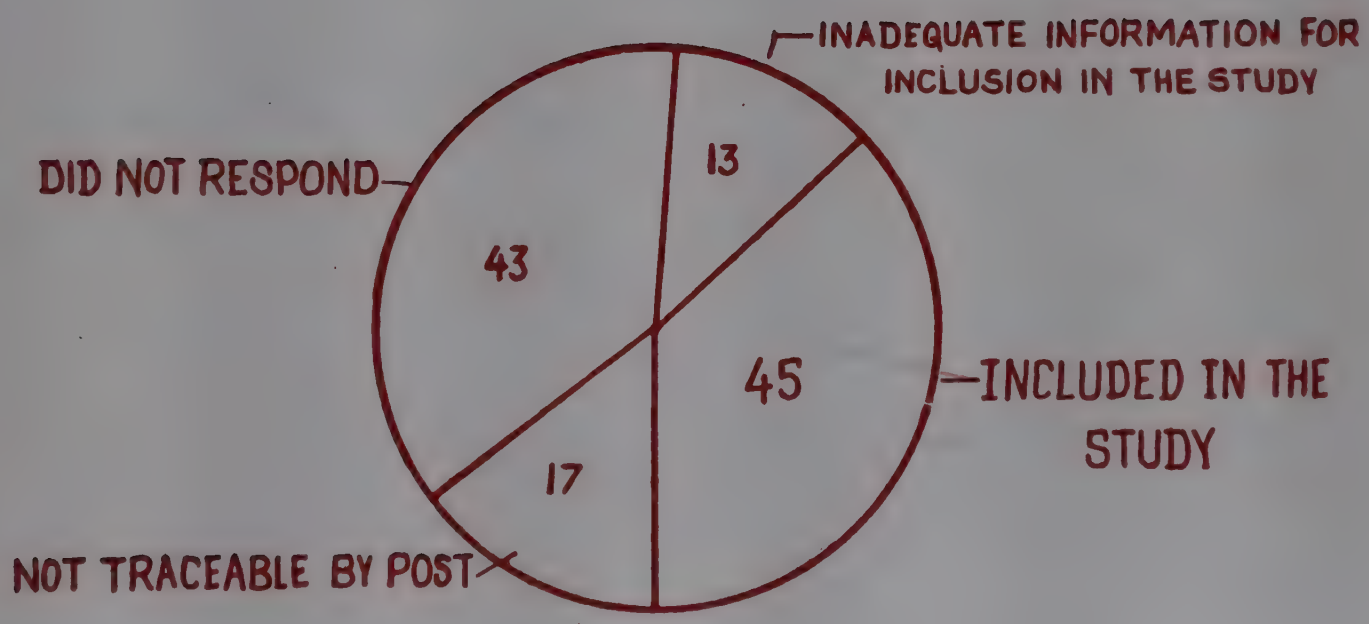
Subsequently we categorised the available data into **eight categories of information (variables) for further analysis** as follows : (i) Area of NGO project location (ii) Objectives of NGOs (iii) Affiliation of NGOs (iv) Commencement Profile and Year of Commencement (v) Organisation structure and Methodology of work (vi) Outreach coverage of health programmes (vii) Activities undertaken by the NGOs and (viii) Finances of the NGOs.

Our analysis is limited to these variables because, as explained later on in Part III, the quality of data relating to other variables (see questionnaire in Appendix 'D') was unsatisfactory or in some cases just not made available.

Figure : 1

NGOS IDENTIFIED BY US

[N = 118]



## PART - III : FINDINGS

In this part of the report the data we gathered on 45 NGOs has been described in detail and subsequently analysed.

This part is divided into nine sections - A through I - each dealing with a separate variable that we have identified for our study. Sections A to H describe in detail each study variable independent of the others, and in section I the interrelationships between variables are analysed.

In the description and analyses that follows we have aggregated the 45 NGOs and no references by name to any NGO have been made. Details of each NGO is presented in Part IV.

## 6. DATA DESCRIPTION AND ANALYSES

An abstract of information available for the 45 NGOs is presented in **Chart 1** (Page 40). In the following sections we present a description of the data and a critical analysis of interrelationships between them. We will also try and indicate trends among NGOs but we leave to the readers to draw the implications that the findings may suggest.

It must be noted that the distribution of NGOs that has emerged in our study is not based on a process of random selection from all NGOs. The selection of NGOs, as discussed in the section on methodology, is from among all NGOs who have been doing some significant work in the field of health - primarily involving community oriented health care services approach; based on various sources of information (which also had their own limitations), we have selected most of the NGOs in Maharashtra who are engaged in such work. Therefore the findings must be viewed and understood only in this context. Further, as indicated elsewhere, an overwhelming number of agencies that operate as "NGO projects" (registered as public trusts) are running private hospitals and dispensaries - they are different from other private sector medical facilities in the sense that they are registered as public trusts or societies and constitute what is popularly known as the "voluntary sector" (what we have called NGOs), and consequently they are eligible for certain tax benefits. It is interesting to note that according to the "Directory of Hospitals in India" (CBHI, GOI, 1981), there are **no private hospitals in Maharashtra** - well known expensive medical establishments such as Breach Candy Hospital, Bombay Hospital and Jaslok Hospital, among others, are listed as voluntary hospitals ! Since the objectives of this study is to look into the 'community health' projects specifically, rather than "voluntary" or "charitable" hospitals, we included only 45 "health" NGOs that **claimed** to be undertaking community health activities; and even after compiling reports on these projects when we found that some were merely operating as hospitals we retained them because they constituted a significant proportion (22% or 10 out of 45).

Categories of information generated from one NGO to another have varied somewhat inspite of the fact that we attempted a standardisation of information through a quasi-structured questionnaire. This variation is due to many reasons. NGOs differ widely in their characteristics, functionally as well as ideologically.

Most NGOs do define bearings on the basis of the categories of information that we have identified for analysis, but at the pragmatic level many NGOs found it difficult to stick to the structured format. Therefore, some areas of information, at times important ones, had to be dropped from our analysis. For instance information supplied on questions about training and work of CHVs, service-charges recovered from the beneficiaries, socio-economic and demographic data, and financial information were inadequately answered. The NGO project profiles (Part IV) clearly reflect these deficiencies and variation. We have, however, gone to great lengths to identify other sources of information about many projects and some success has been achieved. For instance socio-economic and demographic information was obtained from 1981 census records; and other information was collected from various articles and reports (published and unpublished) about NGO projects that we were able to locate. (see Appendix 'E').

The areas of information that we have included for analysis are as follows :

1. Area of NGO project location.
2. Objectives of NGOs.
3. Affiliation of NGOs.
4. Profile and year of commencement.
5. Organisation structure and methodology of work.
6. Outreach coverage
7. Activities
8. Finances.

## A. AREA OF NGO PROJECT LOCATION

**A.1 :** For each NGO, preference of a particular area to start development and/or health activities is a matter of individual choice; but such choices are not made in a vaccum. The NGO takes into account factors like willingness of the community or community leaders to co-operate, accessibility of the project area from its headquarters, organisational objectives and so on. In addition, socio-economic characteristics of the area and its population provides a much more objective basis for selection of an area. For example a project with an objective of giving free medicines to the poor will find it difficult to achieve its goal in a locality where only rich people stay; or a project for agricultural development of poor farmers will only be able to fulfil its goals by selecting an area where greater number of poor farmers reside. Thus, many factors are considered before an area is finally selected. However, the ultimate selection of an area by the NGO is decided by the objective realities that confront them at that point of time. Compromises with local interest have to be made, as establishment of a project generally requires **moving "through the proper channel."**

**A.2 :** NGOs are often characterised as voluntary organisations, that is, they are not private profit making organisations but organisations providing services for development where they are needed most. Therefore analysis of the areas of project location will give us a broad understanding of the NGOs perception of what types of areas and population need their intervention and assistance. It will help in locating trends in project establishment.

**A.3 :** NGOs normally focus their activities on certain **target groups** in the area selected. No doubt this is the best indicator to find out the population units which the NGOs are serving. Though the NGOs focus on certain sections or groups of people, some of their activities, especially health,are open to one and all in the area. That is, the NGOs normally work for the general development of the area in the field of their interest, with a focus on certain population groups so that their development takes place faster. In short, the geographic unit in which the NGO operates becomes important to understand what types of area are adopted for development work by NGOs.

**A.4 :** In the rural area the smallest unit we can select is a village. Since the NGOs cover more than one village, and villages have different levels of development, an understanding of the social geography of the villages would be the ideal. But the lack of relevant information for all the villages covered by a NGO, and that for all the NGOs in our sample, not to mention inadequacies in evolving a standard method to estimate the level of socio-economic development of a village or a group of villages, made us select bigger geographic units for analysis. We have selected districts and tehsils as our units of analysis.

**A.5 :** The **District** is the major administrative unit of the state. Data for a district is easily available. Moreover the district-wise distribution of NGOs gives us an overview of the **general trend** in the NGOs preference for specific areas in the state.

**A.6 :** An objective indicator of the level of economic development is available upto the district level. The best indicator we could find is the **CMIE-index** of level of economic development for each district of India, calculated by the Centre for Monitoring Indian Economy (CMIE Profiles of District, Bombay 1985). This index is a very rough proxy indicator, and weights allocated to the component indicators are meant to reflect the structure of GNP of the country. The CMIE-index, 1980, for all India is 100 and for Maharashtra 163.

**A.7 :** The CMIE index is calculated by taking into account nine indicators in three sectors of the economy. In the agricultural sector it takes two indicators - per capita value of output of 18 major crops and per capita bank credit for agriculture. In the mining and manufacturing sector it takes three indicators, namely, number of mining and factory workers per lakh of population, number of household manufacturing workers per lakh of population and per capital bank credit for the manufacturing sector. In the service sector four indicators are taken, namely, per capita bank deposits, per capita bank credit to services, literacy (%) and urbanisation (%).

**A.8 :** Taking the all India CMIE index of 100 as the reference point, (we do not use Maharashtra's score as the reference point because Greater Bombay District is largely responsible for its high score) the districts of Maharashtra may be classified into three groups. The first group of districts with a CMIE index score of less than 90 we term as **below average.** This group includes 12 districts namely Wardha (84), Dhule (72), Buldhana (72), Bhandara (72), Osmanabad (65), Akola (65), Nanded (63), Yavatmal (62), Parbhani (62), Bid (62), Chandrapur (59), and Ratnagiri (47). The second group with a CMIE Index of ± 10 of all India Index of 100, i.e. between 90 to 110, we have termed as **average.** This group includes 10 districts, namely Nagpur (110), Kolhapur (106), Raigarh (101), Jalgaon (100), Solapur (93), Satara (93), Sangli (93), Amravati (93), Nashik (90) and Aurangabad (90). The third group termed as **above average** has districts with a score of more than 110 points. It includes four districts, namely Greater Bombay (1138), Pune (211), Thane (188), and Ahmednagar (132). However, Greater Bombay district being a fully urban district, no project from our sample is located in it and so the third group effectively contains only three districts.

**A.9 :** As mentioned earlier, while the index of the level of economic development of a district is yet to be made precise and its methodology yet to be fully accepted by researchers, a standard for a tehsil's level of development still remains ill defined. At the same time, very often the level of development varies so much between tehsils in a district that we must outline the social geography of the tehsil, howsoever approximate or subjective, in order to get a corrective picture of the area in which the NGO is operating. (Tehsil or part of a tehsil is the normal area of operation of an NGO).

**A.10 :** In order to classify the **tehsils** we have combined two observations, namely, certain population characteristics, and our own subjective impression of the area we visited and/or its description by the project staff. The five indicators (population characteristics) used were (1) literacy rate (2) percent of workers in the population (3) sex ratio (4) percent of scheduled caste population and (5) percent of scheduled tribe population. No weight was given to each indicator but its variation from the average of the state was taken as indication of development and under-development. The broad picture thus obtained of a tehsil was then evaluated in the light of our subjective impression of the villages covered by the NGO and classified as backward, developing (average) or developed area. It must be noted that the 5 population characteristics mentioned above were only used as a guideline - the determining factor was our own subjective impression. Therefore, we must keep in mind that this tehsil or project area description is not based on rigidly defined objective criteria but is highly subjective and thus open to correction.

**A.11 :** NGO projects which constitute our sample are spread over 19 out of the 26 (before the recent bifurcations) district of Maharashtra and 43% (19 out of 44) of them (NGOs) are concentrated in the four western districts - Thane (7), Pune (5), Raigarh (4), Ahmednagar (3). Distributing the NGOs into the three categories of districts as defined above, for our sample, we find that 34% (15 out of 44) of the projects are located in above average districts, 36% in average districts and 30% in below average districts.

These figures suggest that **70% (31 out of 44) of the NGOs are concentrated in relatively developed districts** (i.e. average and above average). We compared our NGO list with other NGO lists and they compared favourably (Table 1).

**TABLE : 1**

**Different NGO lists by Type of Districts (Maharashtra)**

| Type of District | NGO Lists (number of NGOs) VHAI List (1980) | AVARD List (1979) | NIPCCD List (1981) | GOM List (1982) | List completed by us (1983) | Study Sample (1983) |
|---|---|---|---|---|---|---|
| Below Average (n=12) | 82 (15.6) | 19 (16) | 15 (13) | 62 (30.2) | 28 (24.1) | 13 (29.5) |
| Average (n=10) | 187 (35.6) | 25 (21) | 18 (15.5) | 73 (35.6) | 32 (27.6) | 16 (36.4) |
| Above Average (n=4) | 256 (48.8) | 75 (63) | 83 (71.5) | 70 (34.2) | 56 (48.3) | 15 (34.1) |
| All Areas (n=26) | 525 (100) | 119 (100) | 116 (100) | 205 (100) | 116 (100) | 44* (100) |

(Figures in parentheses are column percentages)

* The 45th NGO in our sample runs hospitals widely dispersed over the entire state and therefore will not feature in tables on location.

**A.12 :** According to the VHAI list, which enumerates all 'voluntary' hospitals and dispensaries, 49% (256 out of 525) of the NGOs are located in the four (15%) above average districts. The AVARD, NIPCCD, and government of Maharashtra lists enumerates rural development projects of NGOs. The AVARD list indicates that 63% (75 out of 119) of NGOs are in above average districts and the NIPCCD list shows 72% (83 out of 116) in the above average districts. The government of Maharashtra list, like our study sample, places 34% of the NGOs in above average districts - the lower figure in these two lists is because Greater Bombay NGOs are excluded in them. On the other hand the list compiled by us (inclusive of our sample), which includes Greater Bombay district, shows that 48% (56 out of 116) of NGOs are in above average districts and only 24% (28 out of 116) in below average districts (Table 1).

**A.13 : The hypothesis that emerges from the above finding is that NGOs tend to concentrate in economically developed districts.** The least developed districts, which constitute 46% of all districts, on an average (from various lists) account for only between 15% and 30% (Mean=21.4%) of the NGOs in Maharashtra. This then is a contradition within the NGOs perspective, who generally claim to be working for alleviation of backwardness.

**A.14 :** When we look at the location of NGOs of our sample at the tehsil level (Table 2), the most common administrative level of operation of NGOs, a new dimension to the above hypothesis is added. Fifty seven percent (25 out of 44) of all NGOs are located in backward tehsils, and from among NGOs

located in above average districts 53% (8 out of 15) have set up projects in backward tehsils. Combining average and above average districts, in which, 71% (31 out of 44) of our sample NGOs are located, 45% each operate in backward and developing tehsils.

**TABLE : 2**

**NGO Location by Level of Development of District and Tehsil**

| District | Tehsil | | | District Total |
|---|---|---|---|---|
| | Backward | Developing | Developed | |
| Below Average | 11 | 2 | 0 | 13 (29.5) |
| Average | 6 | 8 | 2 | 16 (36.4) |
| Above Average | 8 | 6 | 1 | 15 (34.1) |
| Tehsil Total | 25 (56.8) | 16 (36.4) | 3 (6.8) | 44* (100) |

* One NGO not listed. (Figures in parentheses are column percentages)

**A.15 :** Thus it becomes clear that **where selection of districts are concerned, NGOs prefer average and above ones, where infrastructural facilities are adequately developed, but within these districts they tend to prefer backward tehsils.** From the perspective of the NGO, populations in backward areas are most needy of their services and also such populations are most willing to "participate" in programmes of NGOs because public programmes are least accessible to them. Further, observations from our visits to various NGO projects and discussions with project staff reveal that the specially directed (outreach) programmes are invariably designed to reach the lower strastas of the community. This added dimension **apparently** absolves the NGOs to an extent from the earlier mentioned contradiction.

**A.16 :** For the purposes of further analysis, in order to establish interrelationships with other variables (see section I) we have classified NGO location into three areas as indicated below :

| | **District and Tehsil Description** | **Area Status** |
|---|---|---|
| a) | Below average district and backward tehsil, average district and backward tehsil, below average district and developing tehsil. | Backward (n=9) |
| b) | Average district and developing tehsil, above average district and backward tehsil. | Average (n=16) |
| c) | Average district and developed tehsil, above average district and developing tehsil, above average district and developed tehsil. | Developed (n=9) |

## B. OBJECTIVES OF NGOS

**B.1 :** When NGOs set-up a project and define their aims and objectives they generally make a long list for their 'Memoranda of Association', which is a legal document. Since most NGOs are listed as public trusts their defined aims and objectives become a limitation to the range of activities they can undertake and therefore they tend to enlist a wide array of objectives. While most NGOs focus their interest in a few (two to three) well defined fields there are some who do take on a wide range of activities.

**B.2 :** For the purposes of this study cross classifying all enlisted objectives of NGOs would prove quite futile, therefore we extracted their primary objective, keeping in mind their range of activities as well as their evolution. Once this was done comparison among NGO projects was also facilitated. We identified seven prominent areas of interests from among the 45 NGOs that form the scope of this study. These include (i) provision of medical services (ii) community health and related welfare services (iii) demonstration/experimentation with alternative models of Health Care Delivery System (HCDS) (iv) family planning services (v) integrated rural development (vi) leprosy eradication and rehabilitation, (vii) "other" objectives. (Table 3).

**TABLE : 3**

**Objectives of NGOs**

| Providing Curative Medical Services | Community Health Care Services | | Family Planning | Integrated Rural Development | Leprosy Eradication & Rehab. | Others | Total |
|---|---|---|---|---|---|---|---|
| | Service Project | Experiment/ Demonstrate Projects | | | | | |
| 8 (17.8) | 12 (26.7) | 8 (17.8) | 1 (2.2) | 8 (17.8) | 5 (11.1) | 3 (6.6) | 45 (100) |

(Figures in parentheses are percentages)

**B.3 :** Many NGOs run health projects that in reality provide only medical services through a hospital or dispensary. Their aim is to provide medical care to the population at a "reasonable" cost (including profit for their organisation). Such projects we have categorised as **medical services projects.** They constitute 17.8% of our sample. They **do not offer any outreach services,** except for occational medical/ surgical/family planning camps organised in collaboration with other charitable institutions; after all they have to justify their existence as public trusts to claim tax-exemptions. A large proportion of the funds of such NGOs as we shall see later, are generated through medical practice.

**B.4 :** NGOs having regular outreach programme for the community either through ambulatory or domiciliary services have been classified as having **community health** as their objectives. Community health services imply that health care is **available to the community at their doorstep on a regular basis.** There are various ways in which projects reach out to the community with services. They may either use professional paramedics, like MPWs and ANMs, or may train village level workers from the recipient village, who are normally referred to as VHWs or CHVs. Also mobile services as a support to field-workers may be provided. Twenty (44.5%) NGOs in our sample have community health care as their primary objective; and eight of these have been projects who have had their aim to demonstrate

an alternative model of health care delivery, especially the use of CHVs. The latter projects have been decisive in influencing government policy into adopting the CHV scheme.

**B.5 :** Provision of **family planning services** is another important objective. Such NGOs promote family planning vigorously through field workers and hold camps for delivering contraception services. Though 19 NGOs in our sample indicated family planning services as an important activity only one NGO (2.2%) had it as a primary objective.

**B.6 :** Health care delivery forms only one component of NGOs that have **integrated rural development** as their primary objective. Such NGOs are involved in a wide range of activities that are mainly related to agricultural development - promotion and demonstration of modern agricultural methods, water resource development, equity programmes etc. Eight NGOs (17.8%) in our sample have indicated IRD as their main objective.

**B.7** There are a substantial number of NGOs who have taken up work solely in the area of **leprosy** providing a wide range of services and facilities to leprosy patients. They include treatment, rehabilitation and vocational training centres, as well as asylums. In our sample we have five (11.1%) such NGOs. Three of them have set up asylums and the remaining two use a domiciliary appraoch. All these NGOs are affiliated to Gandhian institutions.

**B.8 :** Among the NGOs we have classified as having **"other"** objectives are included those NGOs who are running education projects (two) and those doing conscientisation work (one). All the three (6.6%) NGOs however have significant health programmes as part of their activities.

**B.9 :** The above categorisation of NGOs is only in terms of their main current objective (except for projects that have been terminated). NGOs may have a series of objectives and the above classification should not be seen as an attempt at "bracketing".

## C. AFFILIATION OF NGOS

**C.1 :** Objectives by themselves appear meaningless. Indication of affiliation of the NGO adds an important dimension which may highlight vested interests as well as help us in understanding better the structure and activities of the respective NGOs. For our study we have classified six categories of affiliation. They include (i) Religious (ii) Political (iii) Corporate (iv) Gandhian (v) Public Welfare and (vi) None (Table 4).

**TABLE : 4**

**Affiliations of NGOs**

| Religious | Gandhian | Corporate | Political | Public Welfare | Nil | Total |
|---|---|---|---|---|---|---|
| 10 (22.2) | 8 (17.8) | 5 (11.1) | 5 (11.1) | 14 (31.1) | 3 (6.7) | 45 (100) |

(Figures in parentheses are percentages)

**C.2 :** NGOs owing direct allegiance to **religious** groups or having some association either as a fund recipient and/or ideologically, constitute a large proportion of NGOs. Historically, such groups have been pioneers in community development activities, and especially so in health care. In our sample

10 NGOs (22%) have been identified as having religious affiliation. Eight of these ten are associated with Christian missions.

**C.3 :** **Political** affiliation does not necessarily mean here affiliation to a political party but also includes the process of politicisation. The party affiliated NGOs see their work in health and development as via media for expanding and strengthening their political base while the non-party political NGOs consider the process of politicisation as strengthening the bargaining power of the underprivileged in eking out a more decent share of resources and wealth. Five NGOs (11%) in our study may be classified as having political affiliation, and among them two NGOs have links with political parties.

**C.4 :** NGOs supported or run directly by business houses have been categorised as having **corporate** affiliation. Agencies working with corporate support are generally run through public trusts created by the business house itself, though sometimes business houses may also support other trusts or institutions. The latter type of support was more common before the seventies, but after the seventies, due to certain changes in the income tax laws, direct intervention by the corporate sector became more profitable. We have classified five NGOs (11%) as having corporate affiliation.

**C.5 :** NGOs classified as **Gandhian** are those that are either run directly by Gandhian institutions or are institutions that are ideologically Gandhian/Sarvodaya in character. In our study there are eight (17.8%) NGOs that fit this category. Most of the Gandhian NGOs in our sample (5 out of 8) are working in the field of leprosy. Gandhian organisations generally run large institutions and are mostly charity-oriented.

**C.6 :** Fourteen NGOs (31%) in our sample did not have any specific affiliation as described above. They are public trusts with no particular ideological or institutional attachment. Most of them (10 out of 14) are running hospitals or dispensaries and many have also adopted the community health approach. A few of them (3 out of 14) are IRD projects. Their major aim is **public welfare** by providing services at reasonable cost or without any cost to the community. These NGOs, not being associated with any larger organisation/association, have a greater deal of flexibility in their functioning.

**C.7 :** There are three projects we have classified as having **no affiliation.** Two of these were government sponsored pilot projects (now terminated) and one is a project run by a University department of rural development.

**C.8 :** It must be noted that the above categorisation is not exclusive. It has been done for the convenience of the study. Thus a NGO classified as "political" which is politicising communities through various issues could also have been classified as a public welfare project. Or a NGO classified as a public welfare project but receiving a large volume of church funds (but without any obvious church or religious affiliations) could also have been categorised as having religious affiliation. Therefore, each NGO may have links with various bodies or institutions. We identified the main focal affiliation based both on our observations and information available to us as well as on the answer that the agencies provided to the question on affiliation in the questionnaire we sent them.

## D. COMMENCEMENT PROFILE AND YEAR OF COMMENCEMENT

**D.1 :** From the point of view of understanding the community health approach it is important to understand how the NGO projects commenced, and in which year, because the genesis of this approach was only at the turn of the seventies. By the latter half of the seventies, after India officially adopted

the CHW scheme in 1977 and the World Health Assembly endorsed it in 1978 at Alma Ata, this approach had acquired an international recognition as the best approach towards realising Health for All by 2000 AD.

**D.2 :** Further, the commencement profile and the year of commencement of NGO are extremely useful for understanding the evolution of the project - especially the changes that have taken place in its structure and mix of activities.

**D.3 :** **Commencement profile** refers to the manner in which NGOs begin their projects, that is, the activity-mix they start with. Since our study focus is 'health', we have classified commencement profile as follows :
(i) Community health (ii) Medical care and (iii) Non-health. (Table 5)

**TABLE : 5**

**Year of Commencement by Commencement Profile**

| Year of Commencement | Commencement Profile | | | |
|---|---|---|---|---|
| | Community Health | Medical Care | Non-Health | Total |
| Before 1970 | 2 | 7 | 5 | 14 (31.1) |
| 1970 - 76 | 5 | 10 | 0 | 15 (33.3) |
| 1977 - 80 | 7 | 4 | 0 | 11 (24.5) |
| After 1980 | 3 | 2 | 0 | 5 (11.1) |
| Total | 17 (37.8) | 23 (51.1) | 5 (11.1) | 45 (100) |

(Figures in parentheses are percentages)

**D.4 :** **Community health** profile is attributed to those NGO projects that began with community outreach health programmes right from their commencement. **Medical care** NGO projects are those which began with a hospital or dispensary located at a fixed centre where people were required to go when they fell ill, rather than services being offered at their doorstep through outreach programmes. And NGOs starting with programmes other than health have been categorised as having a **non-health** commencement profile - these include water resources development, agricultural programmes, education, etc. In our sample only 38% (17 out of 45) of the NGOs commenced with community health programmes, whereas 51% (23 out of 45) began with medical care programmes.

**D.5 :** As indicated earlier, in order to understand the evolution of projects we classified them into four categories (year of commencement): (i) those beginning before 1970, (ii) those between 1970 and 1976, (iii) those between 1977 and 1980 and (iv) those after 1980.

**D.6 :** This categorisation has been done keeping in mind the changes that have taken place in the approaches and methodology of NGOs. For instance those beginning before 1970 are charity-oriented

and all those (in our sample) who began after 1970 began with health/medical programmes. Further, 1970-76 is the period during which experimentation with the community health approach was conducted and the year 1977 may be regarded as a "watershed" because in that year the government also approved of the CHV scheme and launched it.

**D.7 :** Fourteen NGOs (31%) from our sample commenced before 1970, and out of these 64% (9 out of 14) began with medical and health programmes and the remaining 36% with non-health programmes (Table 5). It is interesting to note that among these NGOs who began with non-health programmes all of them give the least priority to health and only one of them is currently using the community health approach. Further, among our 45 NGOs all beginning with non-health programmes commenced before 1970. This means that all NGOs who started projects after 1970, even if their objective was other than running health and medical programmes, began with health and medical activities. **This then gives credibility to the much propagated hypothesis that health-care is a good (or popular) entry point.**

**D.8 :** Between 1970 and 1976 15 NGOs (33%) from our sample had launched their projects and out of them only one-third (5 out of 15) started with community health programmes. This period, as pointed out earlier, is important from the point of the community health approach because it was during these years that experiments in community health began in India. All the five NGOs listed in this period as beginning with community health, are those who set up experimental/demonstration projects in community health. The remaining ten NGOs (67%) who started in this period began with medical care programmes (Table 5).

**D.9 :** After 1977 (upto 1983) 35% (16 out of 45) of NGOs in our sample were established, and out of these 63% (10 out of 16) began with community health programmes. This shows that after the government accepted the community health approach as a policy and the WHO endorsed it, a large number of NGOs began to adopt it, not only because community health had become the official policy but also because firstly there was adequate funding, both government and international easily available, and secondly in the sixth plan NGOs were granted an official status to become coparceners in all government's development programmes.

## E. ORGANISATION STRUCTURE AND METHODOLOGY

**E.1 :** Structure and methodology are related issues. Depending on the methodology for implementation of its objectives, an agency defines for itself an organisational structure. Of course, there are constraints such as financial and human resources, social geography of the area selected for work and the defined objectives of the organisation, especially in relation to its affiliate. Also the mix of activities and the scale at which they are to be implemented are determining factors.

**E.2 :** The intricacies of interrelationships among these various factors will be traced in a later section. Presently, we will describe the various types of structures used by NGOs for running health care services.

**E.3 :** **Methodology** of work is directly reflected in the organisational structure used for health care delivery and it is largely dependant on the objectives and philosophy of the NGO. Methodology for delivery of health services by NGOs may be dichotomised into two categories - medical services approach and community health approach (Table 6).

**TABLE : 6**

**Methodology and Organisational Structure (for health care) of NGO Projects**

| Community Health | | Medical Services at Health Centres only | Total |
|---|---|---|---|
| With Paramedics | With CHVs | | |
| 6 (13.9) | 23 (53.5) | 14 (32.6) | 43* (100) |

(Figures in parentheses are percentages)

* Two NGOs do not deliver health care services; one has discontinued and the other only trains CHVs.

E.4 : **Medical services** approach involves provision of mainly curative services in a hospital or dispensary, like any private dispensary or hospital. Generally, such hospitals/dispensaries are established in easily accessible tehsil towns or sometimes in a large village, usually a market place. No effort is made by such NGOs in reaching out to the community for offering services, except for occassional medical/surgical camps - and that too for justifying their existence as public trusts.

E.5 : The **community health** approach rests on the idea of using local personnel for providing health care at the doorstep of the community. Either professional paramedics or locally (from the village) selected men and women are trained and located within the community to provide services. The whole idea is to decentralise a large proportion (50% to 80%) of health care so that unnecessary travel and other expenses are not incurred to attend a health centre.

E.6 : Accordingly, **organisational structures** are evolved by NGOs to meet their objectives. A hospital or dispensary with centre-based medical and paramedical personnel constitutes the staff of the medical services NGOs; often, visiting medical staff are also part of their structure. In some cases fixed sub-centres are operated on a routine basis with the help of visiting medical and/or paramedical personnel. Depending on the size of the organisation and the facilities offered, the staff include a complement of doctors, nurses, ANMs, MPWs, ward-boys, administrator, clerical staff and others. And further, if other activities (non-health) are pursued, then other relevant personnel are also there.

E.7 : Community health NGOs have a more or less similar structure at the health centre. In addition they have field staff, both workers and supervisory; most staff (workers) are located in the area of their work and a few travel on a regular basis to provide support and supervision.

E.8 : Among the field staff the village level health workers, referred to as CHVs (community health volunteers) or VHWs (village health workers), constitute the most important component of the structure. They are the mainstay of the community health approach. These VHWs live within the community they serve and are able to treat most of the common illnesses. Most NGOs use women as village health workers. The paramedics used by NGOs are not village based workers but serve a number of villages on a routine ambulatory schedule. The paramedics provide supportive services and are also first line supervisors. Many projects also have a team of health centre based personnel providing additional supportive services, generally, on a fortnightly basis if there is paramedic support, or on a weekly basis if no paramedic support exists.

E.9 : At the health centre NGOs have a managing committee headed by the project-in-charge and include senior staff, and in some cases local leaders as well as external advisors as members. This

constitutes the decision-making, planning and programming body for an overwhelming majority of NGOs; a few NGOs do have regular meetings of their workers in order to understand their problems and discuss strategies and action programmes; but only in isolated cases are decisions left to the workers. Participation of the community in planning and programme formulation is conspicious by its absence.

**E.10 :** Twenty-nine NGOs (or 67%) are using the community health approach and among them 79% (23 out of 29) use community health volunteers (Table 6). Out of the 23 NGOs who use CHVs 16 also have paramedical workers who supervise and provide supportive services. And 32% of the NGOs (14 out of 43) operate only health centres without any significant outreach programmes.

## F. OUTREACH COVERAGE

**F.1 :** "Outreach" refers to active health programmes initiated by NGOs at the community level. Such coverage by NGOs may be either through mobile services or through fixed sub-centres or through trained village level health workers.

**F.2 :** As seen in section E, village level health workers constitute the most important category for outreach among our sample NGOs. This type of outreach, as indicated earlier, is the main focus of the present study. Use of paramedic workers is less popular as a method of outreach, mainly because paramedics have specialised training and a higher level of education which are demotivating factors for staying within the village itself. Paramedics stationed at sub-centres also tend to stay at a nearby town.

**F.3 :** As regards outreach coverage we have divided the NGOs as follows : (i) those having no outreach services or no health outreach services, (ii) those covering less than 10,000 population, (iii) those covering between 10,000 and 25,000 population, (iv) those covering between 25,000 and 100,000 population and (v) those covering more than 100,000 population.

**TABLE : 7**

**Outreach (Health Programmes) Coverage of NGOs**

| No Outreach* | Upto 10,000 Population | Between 10,000 and 25,000 Popuin. | Between 25,000 and 100,000 Popuin. | More than 100,000 Population | Total |
|---|---|---|---|---|---|
| 6 (35.5) | 3 (6.7) | 12 (26.7) | 10 (22.2) | 4 (8.9) | 45 (100) |

(Figures in parentheses are percentages)

* includes NGOs having non-health outreach programmes.

**F.4 :** Twenty-nine NGOs (64%) from our sample have regular outreach health programmes and amongst them 12 NGOs cover between 10,000 and 25,000 and another 10 NGOs between 25,000 and 100,000 population. This means that 76% of the NGOs who have outreach programmes cover on an average between 10,000 and 100,000 (Mean=47,500) population.

**F.5 :** The extent of coverage by a NGO project is determined by a number of factors which we shall examine later. Here it would suffice to note that each classified category has distinct characteristics and the classification has been designed keeping those features in mind. For the purposes of this study we have considered only health outreach programmes.

## G. ACTIVITIES UNDERTAKEN BY THE NGOS

**G.1 :** All NGOs are registered bodies and so their stated aims and objectives normally cover a very wide array of activities in the field of health and development. However in the course of time their activities get focused on certain fields.

**G.2 :** We identified 29 types of activities undertaken by the NGOs in our sample. Table 8 enlists the various activities undertaken by the NGOs. The distribution given in Table 8 refers to current activities only (except in the case of terminated projects).

**TABLE : 8**

**Distribution of NGOs by Type of Activities**

| Type of Activity | No. of NGOs | |
|---|---|---|
| Curative medical | 40 | (89) |
| Curative outreach | 32 | (71) |
| MCH (ANC-PNC-DEL) | 23 | (51) |
| Immunisation | 27 | (60) |
| Nutrition | 13 | (29) |
| Health Education | 24 | (53) |
| Family Planning | 19 | (42) |
| Drinking water | 7 | (15) |
| Rehabilitation of handicapped/leprosy patients | 6 | (13) |
| Asylums (leprosy, orphanage) | 8 | (18) |
| Childcare (balwadi, anganwadi, childgrowth monitoring, etc.) | 25 | (55) |
| Agriculture | 15 | (33) |
| Irrigation | 6 | (13) |
| Village industry | 11 | (24) |
| IRDP assistance | 13 | (29) |
| Marketing assistance | 10 | (22) |
| Cooperative formation | 8 | (18) |
| Sanitation | 7 | (15) |
| Forestry | 13 | (29) |
| Alternative energy | 6 | (13) |
| Schools | 18 | (40) |
| Training (health) | 9 | (20) |
| Training (vocational) | 16 | (35) |
| Medical research | 5 | (11) |
| Socio-economic research | 9 | (20) |
| Consultancy/evaluation | 6 | (13) |
| Group formation (women, youth) | 19 | (42) |
| Conscientisation | 4 | ( 9) |
| Others | 10 | (22) |

(Figures in parentheses are percentages)

**G.3 :** The table shows that the most common activities are curative medical and curative outreach. This was expected since the NGOs were selected on the basis of whether they had a health component in their programmes or not. It also shows, however, that most of the NGOs need curative medical work for their activites in the field of health. **Curative services provide them an entry point in the community** and at the same time gives credibility to their other activities, both in the field of health as well as non-health.

**G.4 :** In the field of preventive and social health the popular activities are MCH, immunisation, childcare and health education. Health education is normally not the chief focus of the NGOs, but 53% or 24 NGOs have it as one of their secondary activities. It is evident that in the field of health, women and children are the NGOs' chief target groups. It should also be noted that women are a target group specifically for their reproductive functions and not as a general programme for women's health. Interestingly, two other important pillars of health, which are also essential components of preventive and social health, namely nutrition and provision of safe drinking water, are not priority activities for the NGOs. In fact, the NGOs appear to favour family planning more than drinking water supply and nutrition.

**G.5 :** In the field of "non-health" activities, running schools and giving vocational training are preferred by many NGOs, followed by agricultural activities. Other areas also preferred by them are IRDP assistance, forestry, village industry and marketing assistance.

**G.6 :** There is also an interesting trend in the operational aspect of the activities. Although all NGOs employ their own personnel to implement and carry out their programmes, community's participation at various levels of their (NGOs') activities is considered to be essential by all of them. If we exclude passively accepting services provided by the NGOs from the framework of community participation, it is obvious that the community has to be organised in some way in order to achieve their effective participation. Again, given the reality of the situation prevalent in most of the villages, the gram panchayats normally are not the actual organisation or representatives of the people, especially of those people who are to be uplifted by these NGOs. Therefore a need arises, for both constructive health and developmental activities, as well as for making them socially conscious to initiate processes of organising them. From the above table we can identify three forms of activities which directly involve organising people or groups of people. These activities are, cooperative formation, group formation (Mahila Mandal, Youth Club etc.) and conscientisation.

**G.7 :** From our visit to a number of NGO projects we found that cooperative formation and group formation activities attracted certain socio-economic stratas. Cooperative formation was found to be popular amongst the middle farmers and amongst those who are on the verge of becoming rich farmers. On the other hand group formation activities, especially of women, were popular among the landless and poor farmers. Therefore group formation is more popular than other organisational activities. It should also be noted that though these two activities are for organising underprivileged stratas of people, they do not necessarily lead to their active participation, nor are these formations necessarily self-managed activities. Since the **de facto leadership, control and capabilities to get resources to make them economically gainful are in the hands of the NGOs,** more often than not people become passive participants in these activities. In such a situation our characterisation of these activities as organisational activities in the sense of people's conscious and active participation becomes invalid.

**G.8 :** On the other hand conscientisation activities as the means of organising and promoting participation of people is the least popular of all the activities listed in the above table. As we know con-

scientisation necessarily implies people's education and their own conscious initiative to solve their problems. This activity is inherently participatory. Unfortunately, it occupies the bottom of the table. "Other" activities include religio-cultural affairs, legal aid, road construction, youth camps and vetinary care.

**G.9 : Main Activity of the NGO Projects :** As we observed above NGOs undertake various activities at a time in their project areas. But in course of time, either due to deliberate preference or due to the objective situation (success of some and failure of others) some activities evolve as their major activities and hence a kind of specialisation takes place.

**G.10 :** For purposes of data analysis it is not possible to include all activities that NGOs indulge in. Thus, we have identified their focus set of activities from the complement of all that they undertake. Two sets of activities have been identified - 'main activity focus' and 'main activity secondary' - from among the following nine categories for each NGO; (i) medical, (ii) outreach health care, (iii) MCH/immunisation, (iv) nutrition, (v) family planning, (vi) leprosy, (vii) education and training (viii) integrated rural development and (ix) conscientisation.

**G.11 :** **Medical** means hospital/dispensary based services; **outreach health care** includes field-based health programmes; **MCH/immunisation** includes vaccinisation/prophylaxis programme for children and pregnant women and other programmes especially directed towards women and children; **nutrition** includes special feeding programme for pre-schoolers and pregnant and lactating women; **family planning** includes contraception programmes, mainly sterilisation; **leprosy** includes curative, institutionalisation and rehabilitation programmes for leprosy patients; **education and training** includes programmes directed at both formal and informal education and vocational training; **integrated rural development** include a wide range of non-health programmes like agricultural development, water resource development, equity programmes, cottage industries, construction, cooperatives, alternative energy etc.; and conscientisation means organising a community into perceiving their problems and for taking action. For each NGO we identified one of the above as 'focus' and the other as 'secondary' (Table 9).

**G.12 :** The categorisation of NGOs has been done on the basis of information that they indicated on the questionnaire sent to them, as well as information collected from their reports and through our visits to their projects.

**TABLE : 9**

**Distribution of NGO Projects by Main Activity, Focus and Secondary**

| Main Activity | Focus | | Secondary | |
|---|---|---|---|---|
| | No. of Projects | Percentage | No. of Projects | Percentage |
| Medical | 8 | 17.8 | 6 | 13.3 |
| Outreach Health Care | 11 | 24.5 | 10 | 22.2 |
| MCH/Immunisation | 5 | 11.1 | 8 | 18.0 |
| Nutrition | 2 | 4.4 | 1 | 2.2 |
| Family Planning | 1 | 2.2 | 6 | 13.3 |
| Leprosy | 5 | 11.1 | 0 | 0 |
| Education and Training | 5 | 11.1 | 11 | 24.4 |
| Int. Rural Dev. | 7 | 15.6 | 2 | 4.4 |
| Conscientisation | 1 | 2.2 | 1 | 2.2 |
| TOTAL | 45 | 100.0 | 45 | 100.0 |

**G.13 :** Table 9 shows that 42% (19 out of 45) NGOs prefer hospital/dispensary based medical services and outreach health care as their main activity focus, while 36% (16 out of 45) of them prefer these activities as their main activity secondary. The overlap here is very marginal with only 2 projects having their focus as well as secondary main activity in the form of medical care. MCH/immunisation is more often kept secondary to curative health care and so also is the case of family planning.

**G.14 :** Integrated Rural Development is preferred by 15.6% of the NGOs as their focus but in the category of secondary, it goes down to only 4.4%. In the case of leprosy, no project has it as a secondary activity suggesting that leprosy is very rarely (in this case not at all) combined with an NGOs focus activity. The reverse is the case with education and training which is more preferred as a secondary activity than a focus.

## H. FINANCES OF NGOs

**H.1 :** The non-governmental or voluntary sector has grown tremendously both in number and in its weight in the economy since independence. In 1976, for instance, the NGOs (registered trusts and societies) in Greater Bombay alone commanded assets to the tune of Rs.394 crores, their annual income in the same year being Rs.96 crores and expenditure Rs.58 crores, (Government of Maharashtra, Directory of Public Trusts, Bombay 1979). Since then very rapid growth in number as well as financial inflow in the non-governmental sector has taken place, not only in Bombay but all over the country (See Appendix 'A'). Therefore a macro-study of the non-governmental sector outlining the NGOs sources of funds, their assets, their income-expenditure structure, their overall weight and role in the economy is long overdue.

**H.2 :** In the present study our objective is not to go into the broad economics of the non-government sector but only to get information in order to have a general idea of the NGO finances. Our attempts at getting this information were very frustrating. From our experience, we found that it was not only the insufficient data on this aspect of the NGOs that was responsible for our frustration, but the reluctance of the NGOs themselves to disclose and part with the relevant information is equally, and perhaps more responsible, for our scanty knowledge on this subject. This gap is compounded by the fact that whatever information is available with the government is spread over a number of departments and in each department the method of keeping such information is very different and haphazard. Consequently researchers are required to cross too many bureaucratic barriers, which obviously requires more time and energy. And what you get from various departments is so different, overlapping and inadequate that the data most often confuses and disorients more than it clarifies. In short, since our main objective was not to do an indepth study of the economics of the non-governmental sector, we have used in our analysis whatever data the NGOs supplied to us while answering our questionnaire or through their reports, howsoever inadequate they might seem to be.

**H.3 :** There are two aspects involved in understanding fiscal issues of NGOs. One is its source of funds and the other its expenditure. Both are extremely important in understanding most of the variables discussed above. However it is unfortunate that information made available to us, especially with regard to expenditure, is grossly inadequate for a comprehensive analysis.

**H.4 :** We have classified 'source of funds' into eight categories. Firstly there are NGOs who generate their own funds either on a fee for service basis or through production and marketing of goods or through voluntary (local) donations (or a combination of these). These NGOs do not depend on external funding agencies to carry out their programmes.

**H.5 :** There are NGOs that largely depend on **government funds.** Such institutions are generally referred to as grant-in-aid institutions in administration jargon; they receive government grants more or less on a permanent basis. Thus government funds are their life-line and their (NGOs) general experience is one of 'total harassment'.

**H.6 :** **Christian Church funds** constitute an important source of funding, especially in health care, and there are a large number of "mission hospitals" in the country. Most church funded organisations are directly run by missionaries, but a few exceptions do exist. Mission organisations from various European and American countries are the main funders.

**H.7 :** **Corporate** (Indian) funding has emerged in recent years as an important source for rural development activities because of various tax-deductions provided under the income tax act for donations towards undertaking of rural development and welfare activities. Corporate houses may directly run NGO projects by creating their own trusts or they may fund other NGOs. Corporate houses also have their trusts which fund NGOs - for instance Dorabji Tata Trust and Pirojsha Godrej Trust.

**H.8 :** **International organisations** have emerged in the last two decades as the single-most important source of funds for NGOs. They include international NGOs such as OXFAM and Action Aid, bilateral agencies like USAID and DANIDA, multilateral agencies like UNICEF and WHO, and private foundations like Ford and Rockefeller. Except for bilateral and multilateral agencies (who have to channelise funds through the government) all other international organisations fund NGOs directly.

**H.9 :** Many NGOs get funds in various combinations, the two main ones being **government and international NGOs** and **church and international NGOs.** The eighth category in our classification is that of those NGOs who **did not indicate their source of funds.**

**H.10 :** The above classification has been used to identify agencies in categories of their major funders, that is, roughly their two-thirds of funding. It must be noted, therefore that NGOs may have various sources of funds but for the purpose of analysis we have classified them into categories from where they receive **major funding** - hence the above stated combinations also had to be included.

**H.11 :** As indicated earlier information on expenditure is very inadequate for analysis as only fourteen NGOs out of the fortyfive studied gave some information about their expenditure, and nineteen NGOs provided information about expenditure on health programmes. However, the information given was quite sketchy.

**H.12 :** We have attempted to calculated per-capita expenditure of these projects (total and health) but this we would like to note is only an approximate estimate. Data on finances is the weakest link in this study.

**H.13 :** From the distribution in Table 10 the following characteristics of NGOs pertaining to funding emerge: for 44.4% of the NGOs (20 out of 45) foreign agencies, both international agencies and church organisations are the major sources or one of the major sources of funds. International agencies provide funds to 35.6% or 16 NGOs, and 6 NGOs (13.3%) receive funds from church organisations. The government provides funds in different ways to 26.7% of the NGOs. The government and different international agencies (including church organisations) fund 57.8% or 26 NGOs in our sample.

**H.14 : Per Capita expenditure :** As mentioned earlier most of the NGOs did not provide sufficient information about their finances to enable us to analyse the expenditure structure of their projects.

About 58% (26 NGOs) did not provide information about their expenditure on health care programmes. Let alone programmewise breakup, the agencies were more unwilling to tell us their aggregate income and expenditure, even not as percapita. Consequently, we do not know about the finances of 69% (31 NGOs) of the agencies. The category of non-responders is so high in the small sample of ours that an analysis of the information provided by the rest will not yield very useful results.

**TABLE : 10**

**Distribution of Projects by Source of Funds**

| Main Source of Funds | No. of Projects |
|---|---|
| Voluntary donations patient fees and self-generated funds | 9 (20) |
| Govt. grants | 6 (13.3) |
| Church Organisations | 4 ( 8.9) |
| Corporate Sector | 5 (11.1) |
| International NGOs | 8 (17.8) |
| International NGOs and government | 6 (13.3) |
| Church and International NGOs | 2 ( 4.4) |
| Not Indicated | 5 (11.1) |
| TOTAL | 45 (99.9) |

(Figures in parentheses are percentages)

**TABLE : 11**

**Distribution of Projects by Per Capita Expenditure**

| Per Capita Expenditure | Per Capita Project Cost (Total) | Per Capita Expenditure on Health Programme | |
|---|---|---|---|
| | | With Referral | Excluding Referral |
| < Rs.5 | 5 | 1 | 12 |
| Rs.5 to 10 | 3 | 1 | 1 |
| Rs.10 to 20 | 2 | 2 | 0 |
| ≥ Rs.20 | 4 | 1 | 1 |
| Non indicated | 31 | 26 | - |

**H.15 :** However for those interested in knowing the expenditure structure of the rest of 14 agencies and their projects, we have given the break up in Table 11.

**H.16 :** 86% (12 out of 14) of the NGOs spend less than Rs.5/- per capita for their outreach health programmes (this excludes expenditure on their referral health care centre or hospital, and inputs of the agency into other programmes) and 36% (50 out of 14) of the NGOs spend less than Rs.5/- per capita on their total project cost.

## I. DATA CORRELATES : ANALYSES AND CRITIQUE

**I.1 :** In the earlier sections (A through H) we have presented a descriptive analysis of data categories without going into interrelationships that may exist between them. In this section we shall examine some of the important interrelationships that emerge from our data when variables are cross-tabulated.

**I.2 :** Our focus in the following analysis will be on the community health approach. The various correlates of this approach will be identified and critically examined. The questions that we will raise include: why do NGOs select an area with a particular level of development to set up a project? What factors influence the adoption of a community health approach ? Does the source of funding, especially international, influence the features or characteristics of an NGO ? And what are the determinants of an NGO's activity focus ?

**I.3 :** As described in section E, 29 NGOs (or 67%) in our sample use the community health approach (methodology) to deliver health care services. What are the characteristic features of such NGOs ? Table 12 indicates these features vis a vis NGOs who do not use the community health approach.

**I.4 :** Among NGOs who have adopted the community health strategy or method of providing health care 62% (18 out of 29) are located in average and developed areas (Table 12A) and further, of the 23 NGOs who use CHVs as part of their health care delivery structure (see Table 6) 65% (15 out of 23) are located in average and developed areas. Whereas among NGOs not using the community health methodology for health care delivery 62% (8 out of 13) are located in backward areas (Table 12A). This is then a clear indication that **community health NGOs prefer to locate themselves in areas that have an higher level of development** while most of those not using this methodology of HCD are concentrated in backward areas.

**I.5 :** The above hypothesis is further substantiated by the fact that 65% (13 out of 20) of NGOs who indicated community health as their objective are located in average and developed areas (Table 13A), and 76% (13 out of 17) of the NGOs who began with community health activity (commencement profile) are also located in average and developed areas (Table 13F).

**I.6 :** As regards funding, NGOs using the community health approach are more or less equally funded through Indian and International sources, but an overwhelming majority of NGOs (9 out of 11 or 82%) not using the community health methodology get funds mainly from Indian sources (Table 12B). However, of all NGOs getting funds mainly from international sources 86% (12 out of 14) of the recipient NGOs are using the community health strategy. This means that **international funding agencies generally fund only those NGOs in the field of health who are using the community health methodology for delivery of health care in the rural areas.** It must be noted that the community health strategy in underdeveloped countries is well supported by multilateral agencies, as well as most bilateral and private funding agencies of western countries for three reasons. Firstly it is a low-cost strategy; secondly it 'deprofessionalises'

**TABLE : 12**

| Characteristics | NGOs using Community Health Methodology | NGOs not using Community Health Methodology |
|---|---|---|
| A. Area | | |
| 1. Backward | 11 | 8 |
| 2. Average | 12 | 2 |
| 3. Developed | 6 | 3 |
| TOTAL | 29 | 13 |
| B. Source of Funds | | |
| 1. Indian | 11 | 9 |
| 2. International (incl. church) | 12 | 2 |
| 3. Both | 6 | 0 |
| TOTAL | 29 | 11 |
| C. Commencement Profile | | |
| 1. Community Health | 16 | 1 |
| 2. Medical | 11 | 12 |
| 3. Non-health | 2 | 1 |
| D. Year of Commencement | | |
| 1. Before 1970 | 7 | 5 |
| 2. 1970-1976 | 11 | 4 |
| 3. 1977 & after | 11 | 5 |
| TOTAL | 29 | 14 |

health care and; thirdly it provides a better base for strengthening programmes of family limitation (see World Bank Staff Working Paper No.412: Health Problems and Policies in Developing Countries, 1980).

**1.7 :** Another important factor that needs to be considered in understanding the community health approach is that of how and when the NGO commenced its activities. The commencement profile is organically linked with their objective and methodology and therefore it is not surprising that almost all (16 out of 17) NGOs who began with community health activities are using the community health approach (Table 12C). However, among all NGOs using the community health methodology only 55% (16 out of 29) had begun with community health programmes, while 38% (11 out of 29) started with medical programmes and the remaining seven percent (2 out of 29) began with non-health activities. But interestingly 48% of NGOs (11 out of 23) who began with medical programmes have adopted the community approach (Table 12C). This indicates the popularity of the community health appraoch, and **in the seventies an increasing number of NGO run health projects were adopting community health programmes.** Table 14 shows that before 1970 only 14% (2 out of 14) of the NGOs began with community health programmes. In the period 1970-1976, which we have called the experimental phase for community health projects, 33% (5 out of 15) of the NGOs commenced with community health activities and after 1977 as many as 63% of the NGOs (10 out of 16) in our sample began their projects with community health activities. It may be mentioned here that after 1977, when the community health approach (atleast

use of CHVs) became the official government policy, the role played by international funding assumes an exceptionally great prominence as a source of funds for 'voluntary' health projects.

**TABLE : 13**

| Characteristics | Area of NGO Location | | |
|---|---|---|---|
| | Backward | Average | Developed |
| A. Objectives | | | |
| 1. Community Health | 7 | 8 | 5 |
| 2. Other | 12 | 8 | 4 |
| TOTAL | 19 | 16 | 9 |
| B. Year of Commencement | | | |
| 1. Before 1970 | 8 | 5 | 1 |
| 2. 1970 - 1976 | 3 | 5 | 6 |
| 3. 1977 and after | 8 | 6 | 2 |
| TOTAL | 19 | 16 | 9 |
| C. Affiliation | | | |
| 1. Religious and Gandhians | 8 | 7 | 3 |
| 2. Political and Corporate | 4 | 3 | 2 |
| 3. Public Welfare and no affiliation | 7 | 6 | 4 |
| TOTAL | 19 | 16 | 9 |
| D. Source of Funds | | | |
| 1. Indian | 10 | 6 | 4 |
| 2. International | 5 | 6 | 3 |
| 3. Both | 2 | 3 | 1 |
| TOTAL | 17 | 15 | 8 |
| E. Activity Focus | | | |
| 1. Medical | 4 | 2 | 1 |
| 2. Community health | 6 | 9 | 5 |
| 3. IRD, Education and Training | 5 | 4 | 3 |
| 4. Leprosy | 4 | 1 | 0 |
| TOTAL | 19 | 16 | 9 |
| F. Commencement Profile | | | |
| 1. Community health | 4 | 8 | 5 |
| 2. Medical | 14 | 4 | 4 |
| 3. Non-health | 1 | 4 | 0 |
| TOTAL | 19 | 16 | 9 |

TABLE : 14

Year of Commencement by Commencement Profile

| Year of Commencement | Commencement Profile | | | Total |
|---|---|---|---|---|
| | Community Health | Medical | Non-health | |
| Before 1970 | 2 | 7 | 5 | 14 |
| 1970 - 1976 | 5 | 10 | 0 | 15 |
| 1977 and after | 10 | 6 | 0 | 16 |
| TOTAL | 17 | 23 | 5 | 45 |

**I.8 :** Table 13 cross-classifies selected characteristics of NGOs by the type of area in which they operate. The relationship between objectives and area of location (Table 13A) and between commencement profile and location of NGOs (Table 13F) has been indicated in I.5 above. As in the case of objectives and commencement profile, where our data indicates the bias of NGOs using the community health approach to be located in better developed areas, so also with regard to focus of their activity we see a tilt in favour of average and developed areas. Table 13E shows that 70% of the NGOs (14 out of 20) whose main focus activity is community health (includes outreach curative through CHVs and para-medics and MCH, immunisation, nutrition, family planning and conscientisation - see table 9) are located in average and developed areas.

**I.9 :** As regards affiliation of NGOs there is a similarity of distribution for each type of affiliation in each area (Table 13C). Thus 55% of the NGOs with religious and Gandhian affiliation (10 out of 18) are located in average and developed areas and a similar percent (5 out of 9) of NGOs affiliated to political and corporate bodies are located in average and developed areas. Among NGOs who are independent public welfare bodies and those having no specific affiliation (as explained in section C) 59% are located in average and developed areas. However, in all three categories of affiliation backward area (as location) constitute the single largest category ranging between 41% and 44% (Mean=43%) of all NGOs in that category (Table 13C).

**I.10 :** In the case of funding our data indicates the same trend. Forty-two percent (17 out of 40) of fund recipients from all sources are in backward areas, but a majority of them (10 out of 17 or 59%) get funds mainly from Indian sources (Table 13D). For all International funding only 36% (5 out of 14) of the recipients are in backward areas whereas for Indian sources 50% (10 out of 20) of the recipients are in backward areas. As indicated earlier the main recipients of International funding are community health NGOs.(section I.6) which are also largely located in average and developed areas. Further, Table 15 shows that 71% of International fund recipients (10 out of 14) are NGOs whose main activity is community health and among all NGOs with community health as their main focus activity 50% (10 out of 20) are funded mainly through International sources. Putting these facts together **the bias of NGOs, and especially the community health ones, in favour of areas that have achieved an adequate level of development becomes clearer.** However with our small sample it is difficult to indicate whether the reason for international funding going to NGOs in areas with a particular level of development is because of the area's level of development itself or because of the community health projects which are located in those areas.

**TABLE : 15**

**Funding by Focus Activity**

| Activity Focus | Source of Funds | | | Total |
|---|---|---|---|---|
| | Indian | International | Both | |
| Medical | 5 | 0 | 0 | 5 |
| Community Health | 5 | 10 | 5 | 20 |
| IRD Education and Training | 5 | 4 | 1 | 10 |
| Leprosy | 5 | 0 | 0 | 5 |
| TOTAL | 20 | 14 | 6 | 40 |

**L.11 :** Finally with regard to the type of activity focus, we see that 86% of the NGOs (12 out of 14) who began before 1970 have their main activity focus as integrated rural development and leprosy related work, but for those NGOs established after 1970 84% (26 out of 31) have their main activity focus as community health and medical work (Table 16). It must be remembered that this finding is limited to NGOs who are involved in significant health related work (for instance there are many IRD projects run by NGOs who don't have any health or medical components in their projects and therefore are not part of our sample). The main idea here is to show that in the seventies there was an increased trend of establishing 'Health' NGOs and more so that health work was increasingly becoming an important commencement activity (see Table 14) or entry point for NGOs in rural areas.

**TABLE : 16**

**Activities by Year of Commencement**

| Activity | Year of Commencement | | | Total |
|---|---|---|---|---|
| | Before 1970 | 1970-76 | After 1977 | |
| Medical | 1 | 3 | 4 | 8 |
| Community Health | 1 | 9 | 10 | 20 |
| IRD | 8 | 3 | 1 | 12 |
| Leprosy | 4 | 0 | 1 | 5 |
| TOTAL | 14 | 15 | 16 | 45 |

**L.12 :** To sum up we can definitely say that :

1. There is a preference among 'health' NGOs to select areas which have adequately developed infrastructural facilities so that physical constraints for NGOs are reduced to a minimum.

2. The "community health" NGOs are mostly located in average and developed areas.

3. Funding for community health NGOs comes mainly from international agencies.

4. In the seventies health or medical work as an entry point for NGOs into rural areas has gained in importance.

5. NGOs taking up health programmes are increasingly willing to accept the community health approach, which has to some extent decentralised and deprofessionalised health care delivery.

## CHART I

## ABSTRACT INFORMATION OF NGO PROJECTS

| NGO | Name & Project Location | Area Status | Year of Commencement | Commencement Profile | Structure for HCDS | Primary Objective | Affiliation (Main) | Main Funding Source | Outreach coverage (Populn.) | Total & Per Capita Expenditure (Annual) | Main Activity (Focal) | Main Activity (Secondary) | All Activities |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 01. | Anandsadan, Shirpur, Tal: Shirpur, Dist: Dhule | Backward | 1974 | Medical | CHV/para-medic/ referral | Health & Welfare Services | Religious | International NGOs (Terres de Hommes) & church | 13,000 | Not available | MCH/ Immunisation | Education and Training | Medical curative; outreach curative; MCH; Immunisation; Health Education; Family Planning; Child care; IRDP; Co-op. Formation; Sanitation; School; Training; Group Formation. |
| 02 | Annasaheb Tongaonkar Memorial Trust, Tal: Sindkheda Dist: Dhule | Backward | 1978 | Medical | Hospital/ Dispensary | Medical | Public Welfare | Fee for service and voluntary donations | No outreach | Not available | Medical | Education and Training | Curative medical and outreach MCH; Immunisation; H.E.; schools; Vocational Training. |
| 03 | Balkanji Bari International, Balkanji Bari Ashram, Tal: Dahanu, Dist: Thane. | Average | 1951 | Non-Health | Paramedic referral | Other | Gandhian | Govt. grants & volutnary donations | 15,000 | Not available | Education and Training | Health | Curative medical and outreach Child care; Schools; Vocational Training. |
| 04 | CAFI, Tal: Thane Dist: Thane (Terminated in 1984). | Developed | 1976 | Medical | CHV/ referral | IRDP | Corporate | Corporate Sector (CAFI) | 33,000 | Rs.4,20,000 for entire project (Rs.13 per capita on project & Rs.1.78 per capita on health excl. referral). | IRDP | Health | Curative medical and outreach; Immunisation H.E.; F.P.; Drinking water; Child Care; Agri.; Irr.; Village Industries; IRDP asst.; Marketing asst.; Forest Santn. Schools; Vocational Training; Group Formation; Others. |
| 05 | Chinchpada Christian Hospital, Tal: Nawapur, Dist: Dhule | Backward | 1978 | Community Health | CHV/para medical/ referral | Health | Religious | Church Organisation | 5,000 | Rs.25,000 (excluding referral & transport) Details not available | Health | MCH/Immunisation | Curative Medical and outreach MCH; Immunisation; Child Care; Health Training. |
| 06 | Community Health Workers' Pilot Project, Padgha, Tal: Bhiwandi, Dist: Thane (Terminated in 1977) | Developed | 1976 | Community Health | CHV/para medic/ referral | Demonstration/ Experiment | Nil | Govt. & Zilla Parishad | 1,03,000 | Rs.1,75,000 (6 months) (excluding referral); (per capita annual is Rs.3.30) | Health | Family Planning | Curative medical and outreach MCH; Immunisation; H.E.; F.P.; Consultation/Evaluation. |

| NGO | Name & Project Location | Area Status | Year of Commencement | Commence-Profile | Structure for HCDS | Primary Objective | Affiliation (Main) | Main Funding Source | Outreach coverage (Populn.) | Total & Per Capita Expenditure (Annual) | Main Activity (Focal) | Main Activity (Secondary) | All Activities |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 07. | FRCH, Bombay Tal: Uran & Alibag Dist: Raigarh (Rural Projects terminated in 1981 and 1984) | Developed | 1973 | Community Health | CHV/ referral | Demonstration Experiment in HCDS | Corporate | Corporate sector (Pirojsha Godrej Trust) and ICMR | 30,110 | Alibag: Rs.3,40,000 (Rs.11.30 per capita including referral services) Uran : Rs.1,53,000 (Rs.7 per capita incl. referral services. | Community Health Care Services | MCH | Curative Medical an outreach; MCH; Immunisation; socio-economic research; Consultancy/Evaluation; Group Formation. |
| 08 | Shri Girivanavasi Pragati Mandal, Bombay. Tal: Dahanu, Dist: Thane. | Average | 1975 | Medical | Hospital/ Dispensary | Medical | Corporate | Corporate sector (Somaiya Group of Industries) | No out-reach (only camps) | Rs.57,00,000 (for 7 camps) (Rs.30.70 per capita) | Medical | Medical | Curative outreach; Immunisation. |
| 09. | KASA Tal: Dahanu Dist: Thane, (Terminated in 1978) | Average | 1974 | Community Health | CHV/para-medic/ referral | Demonstration Experiment | Nil | Govt. & International NGOs (CARE) | 74,600 | Details not available (estimated Rs.7 per capita excluding referral services) | Nutrition | Family Planning | Curative medical and outreach; MCH; Immunisation; Nutrition; H.E.; F.P.; Socio-economic Research; Group Formation. |
| 10 | Dr. Kasbekar Memorial Community Vision Trust Tal: Panvel, Dist: Raigarh. | Backward | 1979 | Community Health | CHV/ referral | Health & related services | Corporate | Corporate sector (Hindustan Organic Chemical Ltd.) | 28,500 | Rs.66,000 (Rs.2.30 per capita excluding referral services) | Health | MCH/ Immunisation | Curative medical and outreach; MCH; Immunisation; H.E. |
| 11. | Kushtha Rog Nivaran Samiti, Wakdi, Tal: Panvel, Dist: Raigarh | Average | 1981 | Community Health | Paramedic/ referral | Leprosy | Gandhian | Voluntary donations | 1,72,780 | Not available | Leprosy | Education and Training | Curative medical and outreach; H.E.; Rehabilitation of Leprosy/ handicapped; Asylums; Agri.; Mkt.asst.; Forestry; Vocational training, Others. |
| 12. | Laxminarayan Vikas Pune, Tal: Dapoli, Dist: Ratnagiri (Terminated in 1976 but revived in 1984) | Backward | 1967 | Non-Health | Dispensary (Weekly Clinic) | Demonstration Experiment | Public Welfare | Voluntary donations | No Outreach | Not available | Education & Training | Medical | Curative medical;child Care; School; Others. |

| NGO | Name & Project Location | Area Status | Year of Commencement | Commencement Profile | Structure for HCDS | Primary Objective | Affiliation (Main) | Main Funding Source | Outreach coverage (Populn.) | Total & Per Capita Expenditure (Annual) | Main Activity (Focal) | Main Activity (Secondary) | All Activities |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 13. | Maharashtra Prabodhan Seva Mandal, Tal: Dindori, Dist: Nasik | Backward | 1983 | Community Health | Paramedic only | Health & related services | Public Welfare | Voluntary donations | 6,300 | Not available | Health | MCH/ Immunisation | Curative medical and outreach; MCH; Immunisation; Nutrition; H.E.; Drinking water; Child Care; Coop.Formation; Sanitation; Forestry; Group Formation. |
| 14 | Matru Mandir, Devrukh Tal: Sangameshwar/ Rajapur, Dist: Ratnagiri | Backward | 1954 | Medical | CHV/para medic/ referral | IRDP | Political | Govt. & International NGOs (OXFAM DW Germany, Social Welfare Dept.) | 28,000 | Rs.20,00,000 Rs.6.5 lakhs for health services. (Rs.23 per capita including referral services) | IRDP | Health Care | Curative medical and res.; MCH; Rehab. of Leprosy & Handicapped; Asylums; Child Care; Agriculture; Village Industry; IRDP and Marketing asst.; Co-op. Formation; Schools; Training; Group formation; Conscientisation. |
| 15. | Rajamata Jijau Pratishthan, Bombay Tal: Not specific Dist: Not specific | Not applicable | 1975 | Medical | Hospital/ Dispensary | Medical | Political | Not available | No outreach | Not available | Medical | Family Planning | Curative medical; Family Planning. |
| 16. | Ramakrishna Mobile Hospital, Tal: Amalner, Dist: Jalgaon. | Backward | 1978 | Medical | Hospital/ Dispensary | Medical | Public Welfare | Fee for service | No outreach (only camps) | Rs.32,700 per camp (details not available) | Medical | Medical | Curative - medical; Health education. |
| 17. | Skippo Project of AIWC Tal: Talasari, Dist: Thane (the project is temporarily non-functional) | Average | 1946 | Medical | Dispensary (with mobile services) | Medical | Gandhian | Voluntary donations | No outreach | Rs.20,742 (details not available) | Medical | Health | Curative medical and outreach; Child Care; Group Formation. |
| 18. | FPAI, Bombay Tal: Wada, Dist: Thane | Average | 1979 | Community Health | Paramedic only | Family Planning | Corporate | Corporate sector (Business Houses and their asso. & Trusts) | 80,000 | Not available | Family Planning | MCH/ Immunisation | MCH; Immunisation; Family Planning; Child Care; Village Industries; IRDP assistance; Coop. Formation; Forestry; Schools. |
| 19. | Yusuf Meherally Centre, Tal: Panvel, Dist: Raigarh | Backward | 1962 | Medical | CHV/ referral | IRDP | Political | International NGOs (Durssel-dorf Germany & Rotary) | 15,000 | Rs.12,00,000 (Details not available) | IRDP | Medical | Curative medical and outreach; Drinking water; Village Ind; Marketing assistance; Forestry; Alt. energy; Vocational Training; Others. |

| NGO | Name & Project Location | Area Status | Year of Commencement | Commencement Profile | Structure for HCDS | Primary Objective | Affiliation (Main) | Main Funding Source | Outreach coverage (Populn.) | Total & Per Capita Expenditure (Annual) | Main Activity (Focal) | Main Activity (Secondary) | All Activities |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 20. | CHDP, Pachod<br>Taluka: Paithan<br>Dist: Aurangabad | Average | 1977 | Community Health | CHV/para-medic/ referral support | Demonstration Experiment in health development | Public Welfare | International NGOs (OXFAM) | 43,000 | Rs.3,45,000 (Rs.8 per capita incl. referral services) | MCH/ Immunisation | Outreach Health Care | Consultancy and Group Formation; Medical curative; Outreach curative; MCH; Nutrition; Immunisation; Health Education; Family Planning, Child Care; IRDP assistance; Forestry; Alternative energy Socio-economic research |
| 21. | Kayadhu Rural Development Project,<br>Tal: Kalamnuri,<br>Dist: Parbhani. | Backward | 1983 | Medical | Hospital/ Dispensary with sub-centre | IRDP | Public Welfare | Not available | 6,000 | Not available | IRDP | Conscientisation | Curative medical; Immunisation; Child Care; IRDP assistance; Schools; Group Formation; Conscientisation. |
| 22. | Manavlok,<br>Tal: Ambajogai<br>Dist: Beed | Backward | 1974 | Medical | CHV/para-medic/ referral | IRDP | Political | International NGOs (OXFAM, TDH, AFARM) | 60,000 | Not available | IRDP | MCH | Curative med. and outreach; MCH; Immunisation; H.E.; F.P.; Asylums; Child Care; Agriculture; Irrigation; Village Industries; IRDP; marketing asst.; Coop. Formation; Voc. Train; Group Formation; Conscientisation; Others. |
| 23. | Vivekanand Hospital<br>Tal: Latur<br>Dist: Latur. | Backward | 1966 | Medical | Hospital/ Dispensary with sub-centre | Medical | Religious | Fee for service and voluntary donations | No outreach (fixed sub-centres) | Rs.18,70,000 for entire project. | Medical | Health | Curative medical and outreach; Immunisation; Child Care; Medical Research; Group Formation; Others. |
| 24. | Avatar Meher Baba Perpetural Charitable Trust,<br>Tal: Ahmednagar<br>Dist: Ahmednagar | Developed | 1973 | Medical | Hospital-/ Dispensary | IRDP | Religious | Voluntary donations | No outreach | Rs.13,85,000 for entire project & Rs.3,19,000 on medical component (Rs.10 per patient attending clinic) | Education & Training | Medical | Curative medical; Schools; Others. |
| 25. | Centre for Coop. Research in Social Sciences, Pune,<br>Tal: Munshi/Velhe<br>Dist: Pune. | Average | 1980 | Community Health | CHV only | Other (Conscientisation) | Political | International NGOs (TDH) | 10,000 | Rs.49,000 for entire project (Rs.1.60 per capita on health excldg. referral services). | Conscientisation | Education & Training | Curative outreach; H.E; Child Care; Schools; Socio-economic Research; Group Formation; Conscientisation. |

| NGO | Name & Project Location | Area Status | Year of Commencement | Commencement Profile | Structure for HCDS | Primary Objective | Affiliation (Main) | Main Funding Source | Outreach coverage (Populn.) | Total & Per Capita Expenditure (Annual) | Main Activity (Focal) | Main Activity (Secondary) | All Activities |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 26. | Centre for Studies in Rural Development, Ahmednagar, Tal: Ashti Dist: Beed | Average | 1962 | Non-Health | CHV/paramedic/ referral | Demonstration/ Experiment | Nil | Government | 80,000 | Not available | Education & Training | Health | Curative outreach; MCH; Immunisation; H.E.; F.P.; Child Care; Village Ind.; IRDP assistance; Schools; Vocational Training; Socio-economic Research; Group Formation. |
| 27. | CRHP, Jamkhed, Tal: Jamkhed/Karjat, Dist: Ahmednagar | Average | 1971 | Community Health | CHV/paramedic/ referral | Health & Welfare services | Religious | Church (CMC) & International NGOs | 2,50,000 | Not available (Rs.15 per capita estimated including referral services) | Community Health Care Services | IRDP | Curative medical and outreach; MCH; Immunisation; Nutrition; H.E.; F.P.; Drink.water; Child care; Agriculture; Irrigation; IRDP; & Health Train.; Socio-economic res.; Consultancy/Evaluation; Santn.; Forest.; Alternative energy; Group Formation. |
| 28. | Integrated Health Services Project, Tal: Miraj, Dist: Sangli. (Terminated in 1977) | Average | 1973 | Community Health | CHV/paramedic/ referral | Demonstration / Experiment of HCDS | Religious | Govt. International Agencies (SIDA) & Church (CMC) | 2,16,335 | (Rs.4.10 per capita excluding referral) | Health | Family Planning | Curative medical and outreach; MCH; Immunisation; Nutrition; H.E.; Family Planning; Health Training; Socio-economic Research. |
| 29. | Lokmanya Medical Foundation & Research Centre, Chinchwad, Tal: Mulshi/Velhe, Dist: Pune. | Developed | 1973 | Medical | Hospital/ Dispensary with sub-centre. | Medical | Public Welfare | Not available | 15,000 | Not available | Medical | Family Planning | Curative medical and outreach; Immunisation; Nutrition; Family Planning; Child Care; Agriculture; Alt. energy; Medical Research. |
| 30. | MAM, Hadapsar, Tal: Sirur/Haveli, Dist: Pune. | Developed | 1966 | Medical | Hospital/ Dispensary | IRDP | Public Welfare | Church (Christian Aid & CRS) International NGOs (Arbeifer Wolfhart, OXFAM) | 10,000 | 40,00,000 | IRDP | Medical | Curative med.; F.P.; Drink.water; Asylums; Agriculture; Irrigation; Co-op. Formation; Forest.; Alternative energy; Schools; Voc. Train.; Consultancy/ Evaluation; Others. |

| NGO | Name & Project Location | Area Status | Year of Commencement | Commencement Profile | Structure for HCDS | Primary Objective | Affiliation (Main) | Main Funding Source | Outreach coverage (Populn.) | Total & Per Capita Expenditure (Annual) | Main Activity (Focal) | Main Activity (Secondary) | All Activities |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 31. | Sevadham Trust, Tal: Maval, Dist: Pune. | Average | 1980 | Medical | CHV/paramedic/ referral | Health and related services | Public Welfare | International Agency (USAID) | 20,000 | Not available | Health | Nutrition | Curative medical;MCH; Immunisation; Nutrition; H.E.; Drinking water; Child Care; Schools; Group Formation. |
| 32. | Social Service Society of the Medical Mission, Nityaseva Hospital Tal: Shevgaon Dist: Ahmednagar | Developed | 1974 | Medical | CHV/paramedic/ referral | Health and related services | Religious | Church Organisations (IGSSE-Germany & CRS) | 10,410 | Rs.43,976 (Rs.4.22 per capita excluding referral services) | MCH/ Immunisation | Health | Curative medical and outreach; MCH; Immunisation; Nutrition; H.E.; Child Care; Agriculture; irrigation; IRDP assistance; Group Formation. |
| 33. | Vadu Rural Health, Tal: Sirur/Haveli Dist: Pune | Developed | 1977 | Community Health | CHV/paramedic/ referral | health and Welfare Services | Public Welfare | Government & International NGO (ICMR, Ford Foundation & ZP) | 35,642 | Rs.1,87,272 (only CHV scheme) (Rs.5.25 per capita excl. referral services) | MCH/ Immunisation | Family Planning | Medical curative; outreach curative; MCH; Immunisation; Nutrition; Health Education; Family Planning; Child Care; Sanitation; Medical research; Socio-economic research. |
| 34. | Verala irrigation & Dev. Project Soc., Tal: Not specified Dist: Sangli | Average | 1969 | Non-Health | No health Care services presently | IRDP | Public Welfare | Church (EZE-Germany) International NGOs (AFARM, TROCARE, DW) | No health outreach | Rs.16,50,000 income; exp. details not available | IRDP | Education & Training | Nutrition; Agriculture; Irrigation; IRDP assistance; Forestry; Alt. energy; Schools. |
| 35. | Wanless, Tal: Miraj, Dist: Sangli | Developed | 1977 | Community Health | CHV/paramedic/ referral | Health & related services | Religious | Church Org. through Wanless Hospital | 20,000 | Rs.1,00,000 (budgeted) for entire project (Rs.5 per capita ) Community Health is Rs.32,000 (or Rs.1.60 per capita) | MCH/ Immunisation | Health | Curative medical and outreach; MCH; Immunisation; Nutrition; H.E.; F.P.; Child Care; Agriculture; IRDP assistance; Sanitation; Forestry; Health Training; Vocational Training Group formation. |

| NGO | Name & Project Location | Area Status | Year of Commencement | Commencement Profile | Structure for HCDS | Primary Objective | Affiliation (Main) | Main Funding Source | Outreach coverage (Populn.) | Total & Per Capita Expenditure (Annual) | Main Activity (Focal) | Main Activity (Secondary) | All Activities |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 36. | Anandvan<br>Tal: Warora,<br>Dist: Chandrapur | Backward | 1951 | Medical | Hospital/ Dispensary | Leprosy | Gandhian | Self-generated funds & Govt. grants | No outreach | Rs.80,00,000 (Rs.850/- per leprosy inmate) | Leprosy | Education and Training | Curative med.; MCH; Rehab. of Handicapped/ Lep.; Asylums; Agri; Village Industries; Mkt. asst.; Coop. Formation; Forestry; Schools; Vocational Training; Medical Research. |
| 37. | GMLF,<br>Tal: Wardha,<br>Dist: Wardha. | Backward | 1951 | Community Health | Paramedic/ referral | Leprosy | Gandhian | Voluntary donations & own funds | 18,123 | Rs.19,00,000 for all their centres (separately for Wardha not available) | Leprosy | Education and Training | Curative med. and outreach; H.E.; Rehabilitation of leprosy/ handicapped; Health Training; Medical research; Socio-economic research; Consultancy/ Evaluation. |
| 38. | Kasturba Sarvodaya Mandal, Madhan,<br>Tal: Chandur,<br>Dist: Amravati | Backward | 1946 | Medical | CHV/paramedic/ referral | Health & related services | Gandhian | Govt. & International NGOs (OXFAM) | 15,163 | Rs.52,000 (Rs.3.40 per capita excluding referral) | Health | MCH/ Immunisation | Curative medical and outreach; MCH; Immunisation; H.E.; F.P.; Village Industries; IRDP; Coop. Formation; Group Formation. |
| 39. | Lok Biradari Prakalp,<br>Tal: Ettapally,<br>Dist: Gadhchiroli | Backward | 1973 | Medical | CHV/ referral | Health & related services | Public Welfare | International NGOs (OXFAM, ACTION AID SWISS AID) | 20,000 | 4,50,000 (details not available | Health | IRDP | Curative medical and outreach; MCH; Immunisation; Nutrition; Drinking water; Asylums; Child Care; Agriculture; Marketing assistance; Forestry; Schools. |
| 40. | Maharogi Seva Samiti, Dattapur,<br>Tal: Wardha<br>Dist: Wardha | Backward | 1936 | Medical | Paramedic/ referral | Leprosy | Gandhian | Govt. grants self-generated funds & International NGOs (EPRA, TDH) | 6,000 | Rs.11,40,000 (details not available) | Leprosy | Education and Training | Curative medical and outreach; Rehabilitation of Handicapped / Leprosy; Asylums; Child Care; Agriculture; Village Industries; Marketing assistance: Vocational Training. |
| 41. | Mure Memorial Hospital<br>Tal: Nagpur<br>Dist: Nagpur | Average | 1975 | Medical | CHV/paramedic/ referral | Health & Welfare services | Religious | Church (ICCO-Germany) | 25,000 | Not available | Community Health Care Services | Education and Training | Curative med. & outreach; MCH; H.E.; F.P; Village Industries; Health Training; Voc. Train.; Group Formation. |

| NGO | Name & Project Location | Area Status | Year of Commencement | Commencement Profile | Structure for HCDS | Primary Objective | Affiliation (Main) | Main Funding Source | Outreach coverage (Populn.) | Total & Per Capita Expenditure (Annual) | Main Activity (Focal) | Main Activity (Secondary) | All Activities |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 42. | Vanita Samaj,<br>Tal: Amravati<br>Dist: Amravati | Average | 1893 | Non-Health | No health Care services presently | Others (Education) | Public Welfare | Not available | No outreach | Not available | Education and Training | Education and Training | Child Care; School; Health Training; Vocational Training; Group Formation; Others. |
| 43. | Vidarbha Maharogi Seva Mandal,<br>Tapovan,<br>Tal: Amravati,<br>Dist: Amravati.<br>(Terminated in 1984) | Backward | 1950 | Medical | Hospital/ Dispensary | Leprosy | Gandhian | Govt. grants & self-generated funds. | No outreach | Rs. 34,40,000 (Details not available) | Leprosy | Education and Training | Curative medical; Rehabilitation of Leprosy/ handicapped; Asylums; Agriculture; Village Industries; Marketing assistance; Vocational Training. |
| 44. | Vidharbha Vanvasi Kalyan Kalyan Ashram,<br>Nagpur,<br>Tal: Not specific<br>Dist: Yeotmal. | Backward | 1978 | Medical | Hospital/ Dispensary | Medical | Public Welfare | Not available | No outreach | Not available | Medical | Health | Curative medical and outreach; MCH; Immunisation; H.E.; Schools Vocational Training. |
| 45. | Vivekanand Medical Mission,<br>Tal: Nagpur,<br>Dist: Nagpur. | Average | 1982 | Community Health | CHV/ referral | Demonstration Experiment | Religious | International (Royal Common-Wealth Society for Blind) & govt. grants. | 6,000 | Not available | Nutrition | MCH/ Immunisation | Curative medical and outreach; Immunisation; Nutrition; H.E.; Child Care; Agriculture; Forestry. |

# NGOs IN RURAL HEALTH CARE

## Volume One : An Overview

## SUMMARY OF FINDINGS

March 1986

Foundation for Research in Community Health
84-A, R.G. Thadani Marg, Worli, Bombay 400 018.

## SUMMARY OF FINDINGS

This study, sponsored by the Indian Council of Medical Research (ICMR) analyses at the macro-level various aspects of the intervention of Non-Government Organisations (NGOs) in rural health care, especially those who use alternative models for delivering primary health care.

Intervention of the NGOs in health and development activities is not new in India. It can be traced to Christian missionary activities. Serious non-Christian NGOs also evolved with reforms within the Hindu community and again with the emergence of the Gandhian/Sarvodaya organisations linked to or inspired by India's freedom struggle. Such intervention was predominantly voluntary, although motivated by religious zeal and political ideology. The nature of the NGO intervention, however, underwent gradual change after independence, particularly because the state itself started community development projects all over the country. Various international funding agencies made more resources available to the NGOs and the success of the 'green revolution' attracted business houses to rural development. As a result, the scope and intensity of the NGO intervention has increased considerably, especially in the last two decades. Although precise data on the actual size of the NGO sector in the Indian economy is not available, there seems to be a consensus that it is more than what was hitherto known. Moreover, the government has also decided at the highest level to make the NGOs coparceners in it's development programmes. This has also prompted many researchers and commentators to argue that the government is encouraging privatisation of the public sector. The ensuing controversy has indeed made it more important to understand NGO intervention. The NGO sector is a relatively neglected field of research and therefore a need for much more comprehensive research, both at the macro and micro level, is acutely felt. This study is a contribution towards that end.

The study covers forty-five NGOs working in rural Maharashtra. The state of Maharashtra has a well developed NGO sector. In spite of this, we found it difficult to compile a complete list of NGOs in Maharashtra. Our attempts to prepare such a list made us realise that the number of NGOs active in rural development runs into several hundreds. We, however, short-listed only 118 by selecting those NGOs which appeared to have health as a significant part of their activities. Out of the 118 only 45 NGOs provided adequate information in response to our questionairre and other communications. We visited 23 of

them and stayed in the NGO project sites on an average for three days. The chief aim of our visit was to personally see the dynamics of development initiated by the NGO and to observe their programmes in actual operation and the nature of community participation.

The forty five NGOs covered in the study are spread over nineteen districts of Maharashtra. The information collected from the NGOs and from various secondary sources was standardised and then classified into various categories. This was, in a way, a very difficult task as the NGOs, being legal entities and also not sure of which activity would be appreciated and accepted by the community, stated a wide range of objectives. Further, even for getting funds from different sources a longer list of objectives was maintained in their 'Memorana of Association'. Therefore, in order to evaluate the project as a whole we identified the main activity commensurate with their primary objectives and the methodology used. We have also given adequate emphasis to the type of district and tehsil selected by the NGOs for their projects as it gives a much clearer understanding at the macro level whether the choice of the area made by the NGO could fulfil the need to develop the underdeveloped areas and the poor people living there.

Another important aspect analysed by us is the commencement profile and the year of commencement of the NGO projects. This gives us an insight into the strategies used by different NGOs at different times for making entry into the community to activise them to participate in the project's various programmes. Linked to their objectives and the entry-point strategy is the methodology and their organisational structure, evolved over a period of time, to realise their objectives or say to implement their programmes. Their methodology and strategy also indicate whether structurally the NGOs provide any scope for people's participation in the functioning of the organisation and whether they have institutionalised democratic processes making it possible for the people to participate in the decision making process and thereby, control the NGO and its programmes. The methodology used for programme implementation tells us whether the community is looked at as a passive recepient of benefits or as an active and conscious force evolving and implementing programmes, of course, using the NGOs expertise in the process.

Lastly, all these actions of NGOs cannot be initiated without finances. From where funds come, partially determines the priorities of the NGOs and the mechanism of control. As the community's contribution is limited to making

payment for the services received, it largely helps to perpetuate a commodity or commercial relationship, although the payment made is 'reasonable' or less than that found in the open market.

The data collected for each above mentioned category of information was analysed independently, as well as in relation to each other. It should be kept in mind that in macro analysis, because standardised and abstracted information is used, some of the ethos of the NGO and the people they serve is lost. That is, some of the human elements of their approach get blurred. Further, those who have experienced or observed works of a few NGO projects appreciated mainly the humanitarian side of their work but did not evaluate the implicit implication of their overall work on the broad objectives of the NGOs; they may feel slightly uneasy while reading the findings of this study. But that cannot be avoided because when data is standardised and the information from each project added up the individuality is lost. Thus, it must be realised that **the findings of this study gives only an overview and they have a bearing on the NGO sector in health as a whole and not on any individual project.**

From here let us move to the findings. In this summary of findings we have avoided, as far as possible, all statistics from which the findings are derived and only important highlights are narrated. For fuller details the report may be referred to. The data categories used in the summary are explained in the report.

1. An overview of the distribution of the NGOs in the state of Maharashtra shows a definite pattern. The Maharashtra state has 26 districts (now 30 after reorganisation) at different levels of socio-economic development. It appears that, while selecting districts for locating their projects, the NGOs prefer districts with average and above average economic development where infrastructural facilities are better developed, but within these districts, they tend to prefer backward tehsils. On combining districts and tehsils into levels of development (termed as areas) and observing the distribution pattern of twenty nine community health NGOs in our sample, we find that they prefer to locate themselves in areas that have a higher level of economic development.

2. From our discussion with the NGO project staff of 23 such projects we can safely conclude that the ultimate decision about selecting a particular area for establishing the project was invariably taken by either the trustees/

managing committee of the NGOs or by a person who initiated activities and later formed the trust. In most of the cases the 'official' community leaders or under their direction the community was consulted. In some cases the NGO leaders had directly consulted the community before involving the official leaders. However, this consultation was mainly to find out what services people need and whether they will utilise those services if provided by the NGO. The beginning was never (except in one case) made by organising underprivileged masses to fight injustice or by using and strengthening such organisations for initiating health and developmental activities. The reason as to why the latter course is rarely taken by the projects becomes clear on analysing the primary objectives of the forty five NGOs.

3. Since NGO projects with a significant component of health activities constitute our sample the delivery of medical care is one of the objectives of all the NGOs. More specifically, a majority of the NGOs have their primary objective the delivery of health care to the community at their doorstep on a regular basis. Provision of curative medical services and integrated rural development services are the second most popular primary objectives. Other primary objectives include leprosy eradication and rehabilitation, and family planning. On the other hand, only one NGO puts conscientisation and organisation of people as its primary objective. Thus, for most of the NGOs some kind of service or implementation of programmes is the primary objective. People's self-organisation, control, mobilisation etc. (all of them are often loosely bracketed as 'community participation') are therefore relevant to the NGOs in so far as they help in their delivery of services or in implementation of their programmes. This indicates that the limit to which the NGO can encourage or make efforts to bring exploited masses in the position of control is perhaps, largely pre-determined by the objective with which they commence their projects.

4. Another important aspect concerns motivation of the NGOs to establish projects. This is a very difficult and controversial field. The NGOs with religious affiliation or religious motivation easily admitted and even stated so, although they were not ready to admit that they proselytise people to their religious faith. The NGOs with religious affiliations constitute over one-fifth of our sample. Similarly, affiliation to Gandhian institutions or ideology was also indicated by NGOs and they constitute less than one fifth of our sample. But political and corporate affiliation was not made known easily. Some projects even disputed our statement on this point. The NGOs with such affiliation constitute over

one-fifth of our sample. For a large number of NGOs, constituting slightly less than one third of the sample, it was not possible to pin-point any specific affiliation and so we have categorised them as public welfare bodies. Majority of these are the classical new-trend NGOs, that is, those NGOs which got influenced by the idea of community development.

5. In last two decades, a significant change has come about in the strategy employed by the NGOs to gain entry into the community. Before 1970, beginning with curative medical care was a very popular method for this purpose. In the period between 1970 and 1976-we call it a period of experimentation in community health-the provision of curative medical care still remained popular as an entry point; in fact more NGOs resorted to it than earlier and a significant increase in the number of NGOs using the community health approach took place. The year 1977 was a turning point as in this year, the government inaugurated the community health workers scheme. In the period 1977 to 1980, of the eleven NGOs who started their projects seven commenced with community health as compared to only four commencing with curative medical care. Between 1980 and 1983 this trend has continued but less strongly, we in fact cannot be sure about this last period as we have not included some of the newly started projects in our study.

6. As stated earlier the NGOs are registered trusts or societies, and therefore effectively controlled by their board of trustees or managing committee. In the delivery of health care, however, the NGO projects using the community health methodology have carried out significant decentralisation of primary health care by using village level health workers and traditional birth attendants. This decentralisation is combined with supervision and referral services, the latter with the support of paramedics (MPWs and ANMs) and doctors. Most of the community health NGO projects have evolved a very good feedback system between the field and the health centre of the NGO. But the field level staff has no autonomous decision making power, except in some cases on minor matters.

7. Two-thirds of the NGOs in our sample are having outreach coverage of population. Out of them an overwhelming majority (constituting half of the total sample) prefer coverage between 10,000 and 100,000 population

8. NGO projects undertake many activities at a time. The activities undertaken most often in order of their popularity are : curative medical care,

outreach curative care, immunisation, child care, health education, MCH (ANC-PNC-Delivery), family planning and group formation. The least favoured activities are conscientisation, medical research, alternative energy, irrigation, rehabilitation, consultancy, provision of drinking water and sanitation. These two lists are very telling. It seems that NGOs do not prefer activities in the field of environmental and social health. When we consider activities related to organising community, our earlier point gets further substantiated. Many NGO projects prefer group formation, but the least number of them prefer conscientisation. The conscientisasation method develops social and political consciousness for people's self-organisation. Group formation, without conscientisation, helps in organising the community to utilise in a better way the services of the NGO project and in some cases activates it to start some developmental work. But it does not break the existing power structure in the area.

9. The NGO sector is comparatively less organised and hence, not adequately documented. Data on the NGOs' finances is most difficult to obtain, and as a result they are not very precise. More than sixty percent of the NGOs in our sample did not provide us with adequate information about their income and expenditure. However, we could get sufficient information about their sources of funds. Most of the NGOs receive funds from more than one source. Only one fifth of the NGOs in our sample generate a major portion of their funds from the services they provide and from voluntary donations. The rest depend upon the various Indian and foreign funding agencies and the government. Forty four percent of the NGOs in our sample receive funds from various international funding agencies, including church organisations. The government funds are made available to one-fourth of the NGOs in our sample. Another interesting aspect is that of all the NGOs receiving foreign funds a majority (65%) are located in the average or developed areas, while half of all the NGOs receiving Indian funds are located in backward areas. Likewise international funding is more directed to the community health NGOs while Indian funding is uniformly distributed amongst the NGOs having their main activity focus on medical care, community health, IRDP and leprosy.

10. To sum up we can definitely say that :

a) There is a preference among 'health' NGOs to select areas which have adequately developed infrastructural facilities so that physical constraints for NGOs are reduced to a minimum.

b) The "community health" NGOs are mostly located in average and developed areas.

c) Funding for community health NGOs comes mainly from International agencies.

d) In the seventies health or medical work as an entry point for NGOs into rural areas has gained in importance.

e) NGOs taking up health programmes are increasingly willing to accept the community health approach, which has to some extent decentralised and deprofessionalised health care delivery.

Specific characteristics of each NGO are listed in brief in Chart 1.

---

## PART - IV : NGO PROFILES

The preceding parts of this report provided an overview of the NGO sector and their rural health care projects in Maharashtra. The overview and the accompanying analysis was based on information obtained from 45 NGOs.

In this part of the volume detailed information about each of the 45 NGOs is documented separately. The profiles given a sequential number, have been organised alphabetically within the four administrative regions of the state. **Those preceded with an asterisk have been visited by us.** Two of the profiles, Kasturba Rural Health Project (Madhan) and the Govt. Pilot Project (Padgha) could not be sent for verification due to unavoidable circumstances. The terms taluka and tehsil mean the same thing.

## KONKAN REGION


This region consists of the coastal districts of Greater Bombay, Raigarh, Ratnagiri, Sindhudurg and Thane as well as Nashik, Dhule and Jalgaon (the latter three have now been separated into an independent region). Nashik, Dhule and Thane have concentrated pockets of tribal population. Ratnagiri and Sindhudurg, among the most backward districts in the state, are commonly referred to as money-order economies because they have historically constituted an area of labour reserve for large industrial centres, especially Bombay. Thane's high level of economic development as per the CMIE index is mainly due to Thane city's development as an extended industrial suburb of Bombay city. The tribal pockets of Dhule and Thane districts, and to a lesser extent of Nashik, are fermenting with socio-political conflict and form battlegrounds for all colours of political parties/groups and religious organisations.

## SOCIAL, ECONOMIC AND HEALTH INFORMATION : KONKAN REGION DISTRICTS

| Districts | Population (Persons) 1981 | Urban Populn. (Percent) 1981 | % Area of State 1981 | Density per km. (Persons) 1981 | Average Household Size (Persons) 1981 | Populn. Growth 1971-81 (Percent) | Literates (Percent) 1981 | Female Literacy (Percent) 1981 | Sex Ratio (F/1000M) 1981 | SC Populn. (Percent) 1981 | ST Populn. (Percent) 1981 | SC as % of State 1981 | ST as % of State 1981 | No. of Villages |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GreaterBombay | 8243405 | 100 | 0.2 | 13671 | 5.07 | 38.07 | 68.18 | 60.75 | 772 | 4.84 | 1.02 | 8.91 | 1.46 | – |
| Thane | 3351562 | 44 | 3.1 | 351 | 5.11 | 46.89 | 50.50 | 40.15 | 883 | 2.50 | 21.76 | 1.87 | 12.64 | 1746 |
| Raigarh | 1486452 | 14 | 2.3 | 208 | 5.07 | 26.28 | 45.59 | 34.27 | 1046 | 1.69 | 12.80 | 0.56 | 3.30 | 1827 |
| Ratnagiri (includes Sindhudurg) | 2111311 | 08 | 4.2 | 162 | 4.89 | 6.06 | 47.75 | 38.15 | 1238 | 2.14 | 1.50 | 1.01 | 0.55 | 2038 |
| Nashik | 2991729 | 31 | 5.1 | 193 | 5.87 | 17.69 | 44.36 | 31.85 | 937 | 6.21 | 23.45 | 4.15 | 12.16 | 1742 |
| Dhule | 2050294 | 19 | 4.3 | 156 | 5.75 | 23.35 | 37.51 | 26.01 | 966 | 4.18 | 40.53 | 1.91 | 14.40 | 1516 |
| Jalgaon | 2618274 | 25 | 3.8 | 222 | 5.47 | 23.32 | 48.14 | 34.39 | 950 | 5.89 | 8.25 | 3.44 | 3.74 | 1475 |

| Districts | CMIE Index Score 1980 | Main Workers (Percent) 1981 | Non-Workers (Percent) 1981 | Agricultural Labourers as % of main workers 1981 | Sex Ratio of Agric. Labourers F/1000 M 1981 | Ratio of Agric. Labourers to Cultivators (Percent) 1981 | % Main workers in Non-Agricultural sector 1981 | Average Size of Operational holding (hectares) 1976-77 | Per Capita Production of Food Grains (Kgs) Avg. of 1975-1980 | Avg. Daily Employment in Factories (Per 1,00,000 population) 1977 | Per Capita Bank Deposits (Rs.) 1983 | Per Capita Bank Advances (Rs.) 1983 | % Forests Area (Percent) 1973-74 | % Villages Electrified (Percent) 1984 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| GreaterBombay | 1138 | 34.7 | 64.8 | 0.09 | 243.4 | 77.70 | 100 | 1.3 | 0.2 | 7363 | 9191 | 9814 | 3 | 89 |
| Thane | 188 | 37.8 | 59.7 | 12.90 | 846.8 | 45.80 | 59 | 2.6 | 88 | 3911 | 1343 | 451 | 39 | 84 |
| Raigarh | 101 | 37.4 | 58.2 | 14.21 | 914.4 | 27.30 | 34 | - | 168 | 947 | 575 | 246 | 22 | 85 |
| Ratnagiri (includes Sindhudurg) | 47 | 34.1 | 59.5 | 8.18 | 1107.0 | 12.48 | 26 | 2.7 | 103 | 300 | 564 | 158 | 2 | 88 |
| Nashik | 90 | 40.8 | 56.1 | 26.60 | 1290.4 | 63.04 | 31 | 4.1 | 130 | 1299 | 553 | 338 | 22 | 93 |
| Dhule | 72 | 38.0 | 56.4 | 41.28 | 1022.2 | 112.39 | 22 | 4.4 | 227 | 390 | 267 | 176 | 44 | 84 |
| Jalgaon | 100 | 39.6 | 57.7 | 41.85 | 1001.5 | 123.25 | 24 | 3.4 | 169 | 927 | 393 | 269 | 15 | 100 |

| Districts | Voluntary Hospitals 1979 | Govt.& Local Body Hosp. 1979 | P H C S 1983 | P H C S 1984 | Rural Hosp. 1984 | B C G Vaccination 1983-84 | DPT Vac. 1983-84 | Polio Vac. 1983-84 | T.T. Mothers 1983-84 | T.T. Upto 16 years 1983-84 | Tubectomy 1983-84 | Vasectomy 1983-84 | IUDs 1983-984 | Estimated Eligible Couples 1983-84 | Couples Currently protected by 1983-84 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | Steri-lisation | IUCD | Other Methods |
| GreaterBombay | 177 | 46 | - | - | - | 205635 | 344037 | 432839 | 340932 | 266946 | 46140 | 22677 | 29136 | 1374000 | 569061 | 44991 | 15034 |
| Thane | 26 | 15 | 28 | 85 | 11 | 108339 | 138002 | 103013 | 62843 | 108745 | 23650 | 10844 | 32476 | 649000 | 206922 | 27549 | 20838 |
| Raigarh | 10 | 6 | 18 | 49 | 5 | 45421 | 69942 | 50165 | 48402 | 46138 | 8817 | 5184 | 29238 | 280000 | 93058 | 23210 | 8772 |
| Ratnagiri (includes Sindhudurg) | 23 | 8 | 27 | 99 | 9 | 57473 | 86988 | 44432 | 48590 | 52762 | 8602 | 2889 | 39593 | 378000 | 100590 | 23575 | 18240 |
| Nashik | 4 | 13 | 28 | 85 | 8 | 152287 | 35249 | 132105 | 93157 | 73087 | 23499 | 13287 | 44451 | 558000 | 222138 | 36667 | 17630 |
| Dhule | 31 | 10 | 27 | 68 | 7 | 175300 | 108071 | 67941 | 66150 | 57932 | 14410 | 11084 | 35876 | 371000 | 159609 | 30018 | 14499 |
| Jalgaon | 27 | 7 | 23 | 69 | 6 | 117123 | 128663 | 87044 | 80723 | 67703 | 17499 | 19725 | 35555 | 468000 | 183775 | 30985 | 21876 |

Sources : Compiled from :

1. Census of India: 1981, Series - 12, Maharashtra, Primary Census Abstract Part II-B, Govt. of Maharashtra, Bombay, 1983.
2. Profiles of Districts, Part I : A-K, Part II : L-Z, Centre for Monitoring Indian Economy, Bombay, 1985.
3. Performance Budget, 1985-86 - (a) Family Welfare, (b) Medical (Non-teaching Hospitals), (c) Public Health and Sanitation, Government of Maharashtra, Aurangabad, 1985.

## 01.* ANANDSADAN, SHIRPUR

**Name and Address of Project** : Anandsadan Health Centre,
Shirpur - 425 405
Dhule.

**Project-in-Charge** : Sister Cecily.

This project is run by a Christian Mission group who work among the tribals in 13 villages of Shirpur taluka. It is a health and education project which the mission has been running since 1974. The community health programme was started in 1979 after it was realised that mobile services alone, which reached the village only once in two weeks, were highly inadequate and did not truly meet the health needs of the population.

**Aims and Objectives :**

The project was set up for the social, educational and economic development of Adivasis with whom the mission has been associated since long. Most of the Adivasis who benefit from the project are migrants from Madhya Pradesh. The defined objectives of the project are :

(a) To create awareness about preventive health amongst the Adivasi community and to acquaint them with knowledge about health and hygiene;

(b) To improve health status in every village and thereby reduce and control communicable diseases like T.B., leprosy, skin diseases, and so on.

(c) To train villagers in sanitation and to impress upon them its importance;

(d) To control the mortality rate through immunisation, family planning, and the like, and for that to make use of propaganda measures like posters, slides and film shows;

(e) To have individual and collective discussions and remove blind ideas or superstitions;

(f) To provide basic education to Adivasi children;

(g) To organise women into Mahila Mandals to fight social injustices; and

(h) To assist tribals in taking advantage of government tribal welfare and rural development programmes.

**Social Geography :**

Shirpur taluka is a tribal area inhabited by Bhils and Pawaras. it is a hilly tract having a 14% forest area which is fast declining. All villages covered by the project are beyond 18 kms. from the Anandsadan hospital and most of them are fairly inaccessible having none or very skeletal public transport and other infrastructural facilities.

Shirpur taluka has a population of 2,12,553 spread over 36,081 households making for an average household size of 5.8 persons. The sex ratio is 968 females per 1000 males and the literacy rate is 36.4% (24.4% for females); the literacy rate for tribals, however, is 14.4% (5.6% for females). The non-working population constitutes 55.7% of the total population (48.6% for tribals) and agricultural labourers 50.9% of all workers.

**Organisation and Methodology :**

The Anandsadan Mission has a hospital at Shirpur run by Catholic sisters. The mission has trained illiterate Adivasi women as VHWs in 11 villages. The VHWs are supported by a fortnightly mobile team. They also receive in-service training once in 15 days.

For their education programme there is a trained Adivasi teacher in each village conducting non-formal education for children in the age group six to 10 years. At Shirpur there is a vocational training centre for adivasi boys and girls who complete primary school.

There is also a social-worker who coordinates the extension activities of the project.

**Activities and Achievements :**

In the education programme the teachers trained by the project provide tuition to all school going (primary) children in the project villages and have successfully aroused interest among the Adivasis to educate their children. Though government or Zilla Parishad schools have been existing for years they have not been functioning and therefore the Adivasis had a very poor opinion of schooling. But the project's efforts have generated a genuine interest and now Adivasi children who have been to school are able to take advantage of the government's various training and economic programmes meant for tribals. The teachers are also associated with the community health programme in that they maintain health records for VHWs as well as hold monthly meetings with parents to provide education about child-care and general preventive and promotive health care.

The VHWs are trained in curative and preventive health care; however the focus of their work is on the latter. The VHWs promote ante-natal care, immunisation, hygiene practices, family planning and provide curative services for minor ailments.

The VHWs in a few years have progressed from being shunned by the tribals to being accepted as doctors. The people in these villages now have complete faith in the VHWs; and their people's use of bhagats is now insignificant. In fact, some of the enthusiasm of the VHWs has rubbed off onto even the PHC staff who are now interested in associating with the VHWs. This has given the VHWs tremendous confidence and they are willing to learn more skills.

The VHWs have also established Mahila Mandals in eight villages. Through these Mandals women are made aware of social injustices and exploitation and are encouraged to save part of their earnings instead of giving it away to the husband to be squandered away on liquor. The savings are accumulated with the Mandal and loans given to those in financial difficulty or needing money for health care or even for marriages. They have even organised together to beat up forest guards who attempt molestation or other forms of harassment. Seeing this organisation of women, young men are also eager to form Mandals to take up group activities of mutual benefit.

The project has also helped the tribals in taking advantage of various government training and development schemes. Many girls have received training in tailoring under TRYSEM. Subsequently they have set up tailoring units through loans obtained from government schemes and are now earning Rs.10 to 15 per day.

**Finances :**

The extension projects of the mission are supported largely by the Terre des Hommes, a German funding agency. In 1981-82 TDH gave a grant of Rs.60,000 to meet recurring expenditure of outreach

programmes. The hospital and other expenditures are supported by church funds. However details about expenditure were not made available.

## 02. ANNASAHEB TOGAONKAR MEMORIAL TRUST

**Name and Address of Project** : Annasaheb Tongaonkar Memorial Trust,
Dondaicha, Sindkhede,
Dhule.

**Project-in-Charge** : Dr. R.R. Tongaonkar

The Tongaonkar Trust was founded in 1978. It is attached to a private hospital established in 1967 by Dr. R.R. Tongaonkar. The family trust, an appendage of the hospital, provides free services to the underprivileged through various camps, both at the hospital and in the surrounding villages. The trust is funded through private donations.

**Aims and Objectives :**

The hospital was set-up to cater to a rural population that did not have adequate health care easily accessible to them. It aims at providing sophisticated medical care at a reasonable cost to the population. The trust was set-up to provide free of cost medical relief to the poor and to promote health and social education through regular camps and exhibitions.

**Social Geography :**

The project is situated in the hilly tracts (Satpuda) of Sinkhede taluka. Dondaicha, where the hospital is located, is an urban area with a population of 25,890. The taluka has a population of 2,29,976 with a sex ratio of 968 females per 1000 males. The tribal population is 19% and schedule castes constitute 6% of the population. The taluka is generally backward with poor infrastructural facilities. The literacy rate is 44.4% (30.7% for females) and of all main workers 49% are agricultural labourers (82.6% amongst females); 58% of the population constitute non-workers.

**Organisation and Methodology :**

The private hospital and the family trust were started by family members (2 doctors and one superintendent). Fourteen paramedics assist them. General medical and surgical services are provided on a routine basis.

Free medical, surgical and family planning camps are organised occasionally by the hospital for persons who cannot afford such care ordinarily. This is done with the assistance of the Rotary Club, the local IMA branch and local schools and colleges. The trust in 1980 helped the "Gram Swaraj Samiti" in training 7 village health workers for promoting health education and preventive health care.

**Activities and Achievements :**

The trust's activities are focused around health care and education. The trust organises diagnostic, curative and surgical camps, both at the hospital and in surrounding villages - in these camps all services are provided free of cost. At the hospital on a regular basis there is a free ante-natal and immunisation clinic. Village health workers are trained under the auspices of the "Gram Swaraj

Samiti", an Adivasi village organisation. Health education campaigns are occasionally undertaken using dramas, slide shows, lecture-demonstration and exhibitions. These campaigns highlight ante and post natal care, child care, immunisation, cause and prevention of communicable diseases and about nutritional problems. The trust also runs a book bank for poor and needy students.

From time to time the project has encountered problems from the local leadership because the project holder's family has been associated with the Maharashtra Harijan Sevak Sangh and for other personal reasons.

**Finances :**

The hospital is run on a fee for service basis having an annual turnover (1982-83) of Rs.2,48,578.

The trust is funded through voluntary donations. In 1982-83 its income was Rs.3,476 and its expenditure on medical relief was Rs.2,848 and on education Rs.381.25.

## 03. BALKAN-JI-BARI INTERNATIONAL

**Name and Address of Project** : Balkan-ji-bari Ashram
Bapugaon, Via Dahanu Road,
Dist. Thane 401 602.

**Project-in-Charge** : Dada Shewak

Balkan-ji-bari International (Association for Child and Youth Welfare of the World) was started in October 1951. Bapu Gaon, a tribal village in Thane district (Dahanu Tehsil) of Maharashtra, was named so in the memory of Mahatma Gandhi. The stated motto of the organisation is "Education and entertainment".

**Aims and Objectives :**

The stated objectives are to teach the tribals to clothe and eat properly and provide educational facilities for children and adults.

**Social Geography :**

Thane district has 22% tribal population. But Dahanu taluka has 66% of its population as tribal. 28% of the population is literate and 43% constitutes the workforce; out of the latter 16% are agricultural labourers.

Thus the project is located in an area where the majority of the people are socially and educationally backward.

In its first year of operation the agency covered four villages with 4,500 population. The present coverage is of 15 villages with a population of 15,000.

**Organisation and Methodology :**

The main centre of the agency is the Balkanji-bari Ashram. Most of its activities, like running a creche, Balwadi and Ashram schools are carried out through the Ashram. The Ashram has a qualified

medical doctor who is responsible for health work. The agency also has eight village level workers who are trained in first aid and do multipurpose work which includes teaching, agriculture, spinning, weaving, carpentry and so on. They do not charge for the services rendered. These village level workers are supported by the Ashram dispensary manned by a doctor. Specialist doctors also visit the Ashram from time-to-time, but information is not available about the regularity of their visits and the functions they perform.

**Activities and Achievements :**

Initially the activities were organised with the assumption that tribals lacked proper knowledge of what and how to eat and clothe. The Gandhian ideology of reforming personal life-including personal hygiene appears to be the corner stone of the way in which activities have been organised. The Balkan-ji-bari Ashram was thus established. Later on, a creche, a Balwadi, an Ashramshala for primary school children and a post-basic Ashram Vidyalaya for secondary school children were started. In the Ashramshala and the post-basic Ashram Vidyalaya about 250 boys and girls reside permanently and receive education. All these students are supplied with their basic necessities, including books free of charge by the Ashram. Also, about 250 children in the creche and balwadis are given free nutrition every morning.

Vocational training is a part of the education curriculum and school children are given training in agriculture, spinning, carpentry and so on. The Ashram has 10.5 acres of land. The Ashram inmates, including children, grow paddy, jowar, wheat and vegetables. The Ashram has good facilities for irrigation and they have cattle and a power tiller for cultivation.

The Ashram has its own dispensary run by a doctor. Health check-up of children is held regularly. Medicines are supplied free of cost to the inmates as well as villagers utilising this dispensary.

**Finances :**

The project receives government grants and public donations to meet its expenses. Even individual donors from all over the world send contributions in cash or kind for use by the Ashramites.

## 04.* CHEMICAL AND FIBRES INDIA, THANE

**Name and Address of Project** : Integrated Rural Development Programme,
Village Nagaon,
Post: Dahisar (via Mumbra),
Dist: Thane

**Project-in-Charge** : Mr. P.N. Jakate

This project is a corporate house sponsored project. It was started in 1976. CAFI (part of the IEL group) like many other business houses entered into rural development firstly because of government policy decisions and the tax benefits (after 1977) that would accrue and secondly, the public goodwill that would be acquired for being a socially responsible industrial enterprise. Prior to this project, since 1964, CAFI had taken up agricultural development work and ambulatory health care activities in open villages around its factory.

The project identified a cluster of 33 villages in Thane taluka as advised by the Deputy Collector and CEO of Thane ZP, located a centre and began its activities by conducting a baseline survey in 10 of these villages to obtain information on economic and health conditions in the area. It began with

health activities and gradually diversified into education, agriculture, horticulture and other economic activities.

**Aims and Objectives :**

Underdevelopment and backwardness of the rural community must be attenuated and the corporate sector's assistance support to the government's efforts in this regard is important not only for removal of poverty but also for the growth of the corporate sector. The project is directed towards fulfilling this social responsibility.

The operational objectives set out are :

1. To improve health conditions of the community by setting up a dispensary;
2. To improve environmental conditions conducive to prevention of disease;
3. To help villagers to grow vegetables, develop fishery and poultry for improving their nutrition;
4. To introduce high yielding multiple cropping for socio-economic uplift; and
5. To develop water resources, road links and similar infrastructure.

**Social Geography :**

The project is located in Thane taluka which is 73% urban. However the 33 villages covered by the project are more or less in the interior, accessibility being fairly limited due to a skeletal public transport system. The project estimates a literacy rate of 20% in its area and agricultural labourers constituting 20% of the work force. 80% of the population belongs to the Agri caste and there is a fair sprinkling of tribals in the rest of the population. All the villages are electrified (percent households having electricity connection is not known) and have an adequate supply of potable water throughout the year; also, all villages have easy access to public transport though the frequency is inadequate. The villages are between 15 and 25 kms. from Thane city and the CAFI factory site. According to the 1981 Census, Thane taluka (rural) has a population of 1,73, 276 in which the sex ratio is 850 females per 1000 males, the average household size is 4.8 persons, and the literacy rate is 52% (38.9% female); the non-working population constitutes 38% and agricultural labourers are only 5.8% of the work force; 90% of cultivators are small and marginal farmers.

When the project commenced the major causes of morbidity were scabies, guinea worm infection, gastro-enteritis and malnutrition.

**Organisation and Methodology :**

The project has worked in close collaboration with the government and Zilla Parishad. The project officer, an agronomist and an extension worker are provided by CAFI and rest of the workers/ staff is that of the government.

The health programmes are run with the assistance of the Belapur PHC staff, including CHWs trained by the FWRTC, Thane. There are 16 CHWs in the 33 villages. A health centre has been set up in one village which is central to the area of coverage; here the PHC doctor holds a clinic thrice a week. The health posts in the villages are manned by the CHWs, most of whom are young school dropouts who could not find employment. There is no mobile team visiting the villages. Occasionally,

health and family planning camps are held. Health care is provided to families against an insurance premium of Re.1/- per household per month. Also, in collaboration with the Zilla Parishad, agricultural development and education programmes have been taken up.

It must be noted that most of the resources used by the CAFI project for its activities are government/public body resources. The input provided by CAFI is managerial expertise, co-ordination, follow-up and monitoring.

**Activities and Achievements :**

The CAFI project has four spheres of activity as defined by them: social security, ecological security, economic security and infrastructure creation.

Under social security are activities like health and family welfare, education, creation of drinking water resources, latrines, soakpits and sanitation and drainage, organising youth into young farmers clubs and women into Mahila Vikas Mandals.

The programme for ecological security includes water resources, agricultural land and forest development. Wells and reservoirs have been constructed; acreage under irrigation enhanced and productivity improved through better farming techniques and inputs; training of farmers has been conducted; soil analysis has been done; afforestation programmes have been undertaken and horticulture plantations developed; and fishery, poultry and animal husbandry have been promoted to enhance incomes of families.

Further, under the programme of economic security village crafts, mainly for landless families have been developed (carpentry, hut construction, tailoring, brick-making, bamboo craft)and hand (Ambar Charkha spinning), and marketing of farm products undertaken securing remunerative prices for farmers as well as providing farm inputs at reasonable prices.

Also infrastructural development activities such as road building, construction of community centres for health and education, minor irrigation works, craft centres, storage godowns and huts for landless adivasis have been undertaken.

Evaluation of intervention by CAFI in a few villages show significant improvements in health and income levels of the beneficiary population. However, data for the entire project area is not available.

The project was terminated in September 1984 and handed over to the Zilla Parishad as the defined objectives had been achieved. Presently CAFI has started a new project in Jawhar taluka of Thane district with a group of five tribal villages.

**Finances :**

As stated earlier the project was in collaboration with the government and Zilla Parishad. CAFI's financial inputs (including capital expenditure) between 1976 and 1984 were to the order of Rs.24.7 lakhs; out of which 14% was spent on health care, 24% on agricultural programmes, 11% on education and 34% on infrastructure. The remaining 17% was administrative expenditure.

In the year 1982-83 the total expenditure was Rs.4.23 lakhs.

On an average CAFI has been spending Rs.3.5 lakhs per year on health and rural development out of its annual turnover of Rs.4,680 lakhs. The money spent on rural development is completely tax deductible under section 35 cc of the Income Tax Act.

## 05. CHINCHPADA CHRISTIAN HOSPITAL, DHULE

**Name and Address of Project** : Chinchpada Christian Hospital, Chinchpada, Nawapur taluka, Dhule

**Project-in-Charge** : Senior Administrative Officer

The Chinchpada Hospital is a Christian Mission charitable institution working among tribals. The project covers 11 villages with a population of about 15,000. The outreach community health services were started in 1978 by training village health workers in consultation with the Gram Panchayats.

**Aims and Objectives :**

The objectives have not been clearly defined in the information supplied to us but it is apparent that the project mainly is directed towards providing curative services and some preventive health care to the underserved tribals of Nawapur taluka.

**Social Geography :**

All the 11 villages covered by the project are located in Nawapur taluka of Dhule district. All villages are electrified but only a few of them have piped water and public transport facilities. In the project villages 90% people are small or marginal cultivators and the literacy rate is 10%. The entire population covered is tribal, living in forests. The main crops cultivated are rice and jowar.

The Nawapur taluka has a population of 1,54,677 of which 85% are tribals (93% tribals in rural area) spread over 28,419 households making for an average household size of 5.4 persons. The sex ratio is 999 females per 1000 males for the entire taluka but for the tribal population in rural areas it is 1014 females per 1000 males. The literacy rate in the taluks is 24% (14% female), agricultural labourers constitute 27% of all workers and 47% of the population constitute non-workers. Drinking water is inadequate in the area and tuberculosis and tetanus are rampant.

**Organisation and Methodology :**

The project runs a hospital at Chinchpada (details about the hospital not available) on a charitable basis charging only a nominal amount for services rendered. The project has trained one village health worker for each of its 11 villages. The CHWs are supported by a mobile team that visits each village every fortnight and the CHWs come to the centre once a week to receive regular on-going training and to discuss their problems. The CHWs were selected by the panchayat after the latter had invited the project to start community health services in their village. Initially the CHWs received two months' training. The CHWs receive Rs.50/- per month plus a weekly allowance for their trip to the centre. The CHWs recover the cost of medicines from beneficiaries.

None of the villages covered by the project are in its vicinity - all are located at distances between 9 and 14 kms. The community health project is staffed with a community health director, a nurse, a MPW, an attendant and a driver.

**Activities and Achievements :**

Besides running a hospital the project has been conducting training programmes for CHWs,

running a mobile clinic in villages, conducting immunisation and under five clinics and providing health education. The hospital is a referral centre for chronically ill patients and the mobile team provides supportive, curative services as well as conducts immunisation and under-five clinics regularly. The CHWs provide simple curative service, first aid and also health education.

**Finances :**

The project is funded by Church agencies. In 1983-84 it spent about Rs.25,000 on the community health project (excluding transport). Further details were not available.

## 06. COMMUNITY HEALTH WORKERS' PILOT PROJECT, PADGHA

| | | |
|---|---|---|
| **Name and Address of Project** | : | Community Health Workers' Pilot Project, PHC Padgha,Tal: Bhiwandi Thane. |
| **Project-in-Charge** | : | Health Committee chaired by Chairman of the Health Committee of the Zilla Parishad; implementing agency: PHC Padgha. |

This pilot project was inaugurated on 2nd October 1976 after various staff and CHWs had been trained. The experiment was to be tried out in one PHC area having a population of 1,03,000 spread over 144 villages; it was to last for six months and subsequently its feasibility was to be worked out for replication.

The government had accepted that availability and accessibility of health services to the villagers was grossly inadequate and an alternative solution was necessary. Thus the community health worker scheme which was to be implemented with active participation from local communities was mooted. Padgha PHC was selected for trying out the scheme on a pilot basis.

**Aims and Objectives :**

The main aim of the project was to test out the feasibility of providing primary health care at the village level through a team of community health workers. This team of CHWs with the active support of Basic Health Workers and ANMs was to help achieve the following objectives :

1. Provide primary medical care to the local community by establishing treatment clinics for minor ailments and rendering first aid.
2. Maintain an up-to-date list of eligible couples for family planning.
3. Persuade eligible couples to practice effective family planning methods.
4. MCH care, including immunisation.
5. Preventive and curative services against malaria, leprosy and tuberculosis.
6. Improvement of environmental sanitation, and
7. Assist in the referring of serious cases to higher medical institutions.

**Social Geography :**

Padgha is located in Bhiwandi taluka of Thane district. Bhiwandi is 43% urban with a sex

ratio of 751 females per 1000 males (854 females per 1000 males for rural areas). The literacy rate of the rural population is 42.6% (28.8% female) and the average rural household size is 5.3 persons. Agricultural labourers constitute 18% of the work force and cultivators 32%; non-workers constitute 55% of the population.

Bhiwandi and Padgha areas are easily accessible to the industrial cities of Thane and Bombay which provide opportunities for non-rural occupations. Bhiwandi is also an area of intense communal conflicts.

**Organisation and Methodology :**

The organisational structure was the same as any primary health centre with the regular PHC staff of doctors and paramedics and the field staff of paramedics located at subcentres. To this was added a team of CHWs, one male and one female for every 1600 population.

Padgha PHC had six subcentres and one PHU. There were 18 male basic health workers and 10 ANMs and 6 male and 3 female supervisors for extension activities of the PHC. Under each basic health worker 3 to 4 teams of CHWs and under each ANM 6 to 7 teams of CHWs were placed. The health staff and supervisors were given a training of one week including a reorientation and the CHWs given two weeks training. Medical College internees placed at the PHC were also to be involved in the project.

Each pair of CHWs was given a load about 300 families which were divided equally to cover common areas of health care and the male and female CHWs would have to cover all 300 families for areas of work that were assigned on a sex-specific basis. The CHWs had to work 5 hours a day which included one hour of clinic for treatment of minor ailments and for rendering of first aid; in the remaining 4 hours each had to cover about 25 houses so that each family was visited once a fortnight. At periodical intervals in-service training was also to be imparted. Each CHW was paid Rs.125/- per month. An elaborate jobchart for each category of worker was devised delineating their activities and inter-personnel relations. Evaluation and monitoring were left to the PSM department of GMC College, Bombay.

**Activities and Achievements :**

The CHWs had to organise a clinic for one hour everyday for treatment of minor illnesses and rendering first aid. They had also to provide treatment to leprosy, tuberculosis and malaria patients. In addition to this the male CHW had to carry out work in environmental sanitation and school health.

In their house visits the male CHW had to enquire about fever cases, take blood smears and administer presumptive treatment; enquire about births and deaths; carry out health education; identify and follow-up sterilisation cases.

The female CHW had to enquire about ante-natal cases, pre-school children and register them for ANC services and immunisation respectively; follow-up family planning cases and conduct health education. The paramedics were to carry out their routine tasks as multi-purpose workers (and not vertical workers) and co-ordinate and supervise the CHW's work and activities providing supportive services.

The experiences of this pilot project were taken into account in formulating the CHW scheme for the State of Maharashtra.

**Finances :**

The project was funded by the state and the local bodies in a ratio of 4:1 respectively.

In the 6 month period of the actual functioning of the project Rs.1,75,000 was spent only on the CHW component; 56.5% on CHW honorarium, 24.5% on medicines and supplies and 19% on stationery equipment, etc. The per capita annual cost worked out to be Rs.3.30.

## 07.* THE FOUNDATION FOR RESEARCH IN COMMUNITY HEALTH

**Name and Address of Project** : The Foundation for Research in Community Health,
84-A, R.G. Thadani Marg,
Worli, Bombay. 400 018

**Project-in-Charge** : Dr. N.H. Antia

The Foundation had its beginnings in 1971 when the founder-director, Dr. N.H. Antia made regular visits to the rural area of North Alibag to understand the health and related problems faced by the local population. By the end of 1972 it had become clear that an alternative kind of health care delivery system was the need of the hour. Thus in association with the 3R Society (Society for Reconstruction Surgery, Rehabilitation and Research), which was initiated by Dr. N.H. Antia and with support from Mr. N.P. Godrej - an industrialist - a rural health research project (Mandwa Project) was started in early 1973 in North Alibag taluka of Raigarh district. A baseline study of this area was conducted in 1974 by the TISS on behalf of the Society.

Later, in 1976, another taluka of this district, Uran, was also included to demonstrate the community health model at the PHC level. In both the projects a contract was entered into with the Zilla Parishad granting a time bound technical control of the PHC in Uran taluka and a nearby created PHU at Mandwa. In 1975 the FRCH took over all the functioning activities of this project from the 3R Society by a mutual agreement. FRCH also has an active research cell, undertaking policy and field studies in health and related issues. The Uran project terminated in 1981 and the Mandwa project in 1984. Besides the Bombay research cell, FRCH is now starting several new field projects in other rural and urban areas.

**Aims and Objectives :**

The FRCH's primary aim has been to conduct research, both conceptual as well as into health care delivery systems. The field projects have thus been mainly experiments in understanding the problems of the delivery of health care and in exploring alternative model/s.

The Mandwa project was initiated with the following objectives :

1. To develop an alternative for rural health care based on community participation, which could be replicated in other areas;
2. To select, train and field village health workers (VHWs) as the chief means of promoting community participation and self-help; and
3. Using the VHWs as the agents to develop a grass roots health structure offering curative, preventive and promotive health services.

As regards the Uran project the goals were slightly different because functionally in Uran the methodology was different - to observe and improve the functioning of the existing government Primary Health Centre and its programmes with minimal inputs from FRCH. Thus the operational objectives defined were :

1. Providing only supervisory and training inputs from the Foundation;
2. Selecting and training community health workers (CHWs) (of the government);
3. Reorienting the government staff of the PHC (particularly paramedics) to work as supervisors to the CHWs, rather than first-line workers, and improve their efficiency;
4. To initiate community participation in health activities by involving the Panchayat Samiti and Gram Panchayats and forming people's health committees; and
5. To monitor and evaluate the programme with a view to developing guidelines for the improvement of the PHC system.

Thus 'Mandwa' would demonstrate how a voluntary agency with the same limited resources of the PHC could effectively deliver health care through semi-literate village women and the Uran project was aimed at extending the same idea within the actual framework of the government's Primary Health Care System.

**Social Geography :**

Alibag and Uran talukas, both in Raigarh district on the mainland across the harbour of Bombay, cannot escape the influences of urban living and an industrial way of life; in fact in the last one decade both these talukas have experienced rapid industrialisation and urbanisation, putting in the background rural life styles. Almost all villages in these two talukas have frequent bus services along the main axis; the areas are also well connected with road and sea transport to Bombay city. According to the 1981 census these two talukas together had a population of 2,53,935 spread over 50,128 households averaging a household size of 5 persons and a sex ratio of 1003 females per 1000 males. Alibag taluka has a tribal population of 16%. The literacy rate in these two talukas is 54% (42% female). 57% of the population constitute non-workers, and of the workers 44% work in the secondary and tertiary sectors, and 11% constitute agricultural labourers.

In Alibag taluka the FRCH covered 31 villages with a population of about 30,110. Though this area has easy access to Bombay it was generally backward and health conditions were not very good because of inadequate potable water and poor nutrition due to low income. However, most households had at least one person working in Bombay and adjacent industrial areas. Conditions in Uran, the area where FRCH was working, were somewhat better due to the area itself being industrialised. In Uran FRCH had planned to cover all the villages but due to political problems and lack of interest and co-operation from the PHC staff, it had to confine itself to the western sector of Uran; about 24 villages.

In both the project areas the predominant population is of the Agri caste (80% of the Hindus), Among the rest are Kolis (fisher folk) and Katkaris (tribals - only in Alibag) - middle and upper castes are virtually non-existent; and related to this is the fact that 90% of the holdings are 2.5 acres or less.

**Organisation and Methodology :**

In the Mandwa project area a PHU was constructed by the Foundation. The government provided the basic staff and other inputs of a PHU (approx. Rs.30,000 per annum). This was to be the referral centre with a doctor and a few paramedics - there were 10 beds for maternity and serious cases. The second tier consisted of ANMs, each covering 5 villages - they were to supervise, assist and support the VHWs and also to act as the first line for referral care. At the village level, in each village, was located a female VHW who provided routine curative treatment and organised preventive and promotive health services.

Since the director was based in Bombay, a team comprising a community organiser and an administrator were located at the project site to supervise and co-ordinate the project's activities. In Uran, originally, the FRCH was to provide only the managerial input but because of problems with the PHC staff, a dispensary in the charge of a Public Health Nurse (PHN) in one village and one CHW in each of Uran's western sector villages, comprised the personnel on the project. A government doctor on deputation was also added on for providing referral services - the MPWs and ANMs were highly antagonistic to the FRCH CHW scheme and did not support it. Health Committees were organised in several villages in both Uran and Mandwa. In the field the FRCH from time to recruited persons to experiment and implement various socio-economic programmes. At Bombay is located FRCH's research cell that monitored these field programmes besides carrying on conceptual and field research, mainly for government agencies like ICMR, ICSSR and the state government. Currently FRCH has 5 researchers working on various research projects. FRCH also has an excellent library and documentation unit on health and related issues.

**Activities and Achievements :**

Within the framework of its twin objectives of demonstrating that community health services can be provided by semi as well as illiterate village women and research into health issues, the FRCH has carried out the following programmes :

1. Training of village health workers to provide first line health care including treatment of common ailments, malaria and gastroenteritis, detection of leprosy and tuberculosis and follow-up of its treatment, ante-natal and post-natal services and delivery, child care and immunisation and health and nutrition education;
2. Providing referral care as a support to VHWs;
3. Promotion of family planning through routine motivation by VHWs and not as a camp approach;
4. Sanitation and environmental health promotion, e.g. protection and chlorination of well;
5. Integration of leprosy with primary health care so that leprosy detection and treatment becomes part of routine care which would help remove stigma attached to this disease;
6. Food-for-work programmes for tribals under the 20-point programme.
7. Agricultural programmes like bunding work to prevent flooding from sea-water in a few villages, demonstration of vegetable farming and fish farming; and
8. Nutrition programme (supplementary feeds) for third degree malnourished children.

For curative services the VHWs charged Re.1/- for two days medicines. Immunisations and treatment

of leprosy and tuberculosis was free of cost. The socio-economic and nutrition programmes were only there is the early years of the project.

The research cell has carried out various important studies for the ICMR and ICSSR that have been used for national health policy formulation. A number of micro-studies and field experiments are also being carried out presently.

As regards achievements of the health programmes it may be stated that the strategy of utilising VHWs proved extremely successful in both Uran and Mandwa, making significant impact on various health and demographic indicators. Thus between 1974 (baseline) and 1980 in Mandwa area birth rate declined from 27.3 to 10 per 1000 population, death rate from 15.5 to 5 per 1000; the infant mortality rate in 1980 was 66 per 1000 live births and in the same year 75% of the under-five population was protected through immunisation (DPT, BCG) and 90% of all pregnant women were receiving ANC services. It must be noted that these achievements were inspite of weak support from paramedics and referral services. In Mandwa, ANMs did provide some support but in Uran no such support existed and therefore the VHWs took to giving all immunisations and streptomycin injections (to tuberculosis patients) themselves. Encouraged by this, FRCH gave proper training to the VHWs of Uran in innoculating and also gradually introduced this strategy in Mandwa, eventually replacing the ANMs in the field with its trained VHWs.

The socio-economic programmes (taken up in the early years of the project) of FRCH could not get past the demonstration stage because of organisational deficiencies. The FRCH set up has always been very informal and non-bureaucratic and this ultimately led to it's field projects' undoing because its informal operations could not tackle the bureaucratic structure of administration and politics. Both the projects had to be terminated at the insistence of the Zilla Parishad, inspite of excellent rapport with and support of the Directorate of Health Services.

Finally, it must be noted that post-termination there was an interesting difference between Uran and Mandwa. After closure in Uran the PHN who had worked for FRCH organised four villages to form a co-operative health care dispensary supported directly by the villagers and the salt-pan workers' union, and even today this dispensary caters to villagers of these four villages as well as other nearby villages. After Mandwa's closure the Zilla Parishad did not wish to continue with the VHWs who had worked with the FRCH but instructed the PHCs to train a new batch.

**Finances :**

The main funding for the Bombay research cell has hitherto come from research grants from ICMR, ICSSR and the Damien Foundation, and for the rural projects from the Pirojshah Godrej and Bhiwandiwalla Trusts. It has also received financial support from various agencies such as the Volkart-Foundation, OXFAM, CASA and the Lotus Trust.

In 1983-84, Rs.4,93,000/- were spent by the FRCH (Rs.3,40,000/- on the Mandwa Project) working out to Rs.16.4 per capita (Rs.11.3 per capita on the Mandwa Project). Out of the Mandwa project expenditure, salaries constituted 55%, medicines 15%, documentation 5%, transportation 5% and audio-visuals 5%. Of the total expenditure research constituted 30% (inclusive of researchers' salaries).

## 08. SHRI GIRIVANAVASI PRAGATI MANDAL

**Name and Address of Project** : Fazalbhoy Building, 4th Floor,
45-47, M.G. Road, Fort, Bombay 400 023.

**Project-in-Charge** : K.J. Somaiya (President).

Shri Girivanavasi Pragati Mandal is a charitable institution of an all India character. It was established in 1974 under the patronage of Shri K.J. Somaiya, an industrialist and his son Dr. S.K.Somaiya. It began its medical programme with an eye-cum-medical camp in 1975.

**Aims and Objectives :**

The stated objectives of the Mandal are the uplift and welfare of Girivanavasis (people living in the hills and plains) of India. These objectives are to be realised by organising two types of activities:

1. A short term activity which consists of annual eye-cum-medical camps of three to four weeks duration in the midst of adivasi (tribal) areas in different states and
2. Long term activity consisting of socio-economic uplift of poor tribals around Nareshwadi in Dahanu taluka.

**Social Geography :**

Each year a different area is selected by the Mandal to organise an eye-cum-medical camp. Between 1975 and 1983 the Mandal organised seven such camps covering states of Maharashtra, Gujarat, Rajasthan, Madhya Pradesh, Orissa, Bihar and again Gujarat (Kutch). According to the Mandal the common social-geography of all these areas selected for camps was that they are hilly and forest areas.

They are establishing their long term activities in Dahanu taluka of Thane district in Maharashtra. This area was selected because a large number of tribals inhabit the surrounding area. Dahanu taluka has a tribal population exceeding 65%. Urbanisation is slow with only 7% of its population residing in urban areas. Literacy is very low with only 28% of the population being literate as compared to about a 47% literacy rate in Maharashtra.

**Organisation and Methodology :**

The Mandal's methodology is based on two approaches. First is the camp approach in which eye-cum-medical camps are organised with the help of eminent and expert doctors, nurses and social workers. Even civil engineers are used for site survey purposes and for setting up the camp facilities at suitable sites. Incidentally, the Mandal is run under the guidance of the owners of Somaiya group of industries. In these camps the Somaiya family and even the employees of the Somaiya group of industries participate and serve in a voluntary capacity. Volunteers for camps are also drawn from the students of Somaiya Vidyavihar school and college run under the patronage of the Somaiya family.

To realise its second objective the Mandal is establishing an eye hospital in Dahanu taluka. This will become the base for the Mandals' various village outreach programmes.

**Activities and Achievements :**

Seven camps, each lasting for three to four weeks in a tribal area in different states were organised by the Mandal in the first nine years of its existence. Each camp covered a radius of about 100 miles around the camp site. At each camp most of the medical specialities are represented. In addition, Yoga practical training and discourses, ayurvedic treatment and polio immunisation centres

were also included. In these seven camps totally 1,85,417 persons have been reported as beneficiaries thus, each camp serving on the average about 26,000 persons.

The agency faces two problems whilst conducting its activities. First is the backwardness of tribals which makes them suspicious of the agency's officials organising the camps. To overcome this problem the agency provides transport to the tribals from their villages to the camp site and back. In order to attract them to avail of the medical facilities the Mandal provides them with free food, free treatment and free accomodation during their stay at the camp. The second problem encountered is the hardship that the health personnel have to undergo as the camps are usually held in remote areas.

**Finances :**

No details of the Mandal's sources of funds are available. Possibly, a large part of their funds come from the Somaiya group of industries.

In organising seven eye-cum-medical camps the Mandal spent about Rs.57 lakhs accounting for an expenditure of about 8 lakh rupees for each camp. The expenditure per beneficiary works out to about Rs.31/-.

## 09. KASA MCHN PROJECT

| | | |
|---|---|---|
| **Name and Address of Project** | : | Kasa MCHN Project<br>Institute of Child Health,<br>Grant Medical College,<br>Bombay. |
| **Project-in-Charge** | : | Dr. P.M. Shah<br>(Project terminated in 1978) |

The Kasa MCHN programme was a government and CARE sponsored pilot project to experiment with an alternative design in primary health care through reorientation of a PHC. The task was undertaken by the Institute of Child Health of J.J. Hospital, Bombay, in December 1974 to demonstrate integration of maternal, child health and nutrition services in a PHC area. The project covered 79 villages with a population of 74,600 of which 88% is tribal.

**Aims and Objectives :**

The project's main objective was to establish the administrative feasibility of adopting for large scale implementation, an integrated approach to the problems of rural 0 to 5 year old children and married 15-45 year old women and to nutrition. This was to be achieved through a scheme that would provide for food supplements to malnourished under 5 children and pregnant and nursing mothers in addition to health care and health/nutrition education. These objectives were to be achieved through use of village level workers known as part-time social workers (PTSWs).

**Social Geography :**

The project covered the Kasa PHC area of Dahanu taluka in Thane district. The area is mainly inhabited by tribals and is covered by 6 subcentres. The remotest village is 40 kms from the nearest subcentre.

For the tribal population of Dahanu taluka the sex ratio is 990 females per 1000 males and the average household comprises of 5.4 persons. Among them 10.8% are literate (3.5% females) and 48.9% non-workers; of the workers 20% are agricultural labourers.

The terrain of the project area is difficult and a large number of villages are inaccessible by any transport.

**Organisation and Methodology :**

The project was designed for implementation with the assistance of village level workers who were labelled as PTSWs. The PTSWs were responsible for implementing the nutrition programme for under 5 children and pregnant/nursing mothers and to monitor their progress. They were also trained to provide simple curative services and to promote immunisation and family planning.

Between the PHC and PTSWs were the usual complement of government health services staff like MPWs, ANMs, etc., and 2 MOs at the PHC who had to co-ordinate and supervise the staff for the project's activities. These staff were to be supported by a medical researcher (for 1 1/2 year only), a field research officer and a programme officer who were to monitor, survey, carry out studies, process information and co-ordinate all programme activities. Co-ordinators from CARE, Rural Development and Public Health Departments, under guidance of two project directors, constituted the apex body responsible for project planning and implementation.

The project started with nutrition and health (curative) programme because that was most easily acceptable to the tribals. Before commencement of the nutrition programme a survey to identify **at risk** children and mothers was conducted. As confidence of the people was gained immunisation and family planning services were increasingly promoted and provided. Out of the 79 villages identified, 19 were maintained as control villages to study the impact of the new integrated design. The project also organised an elaborate information system to enable monitoring and evaluation.

**Activities and Achievements :**

The project's main thrust in the beginning was its nutrition programme for pre-schoolers and pregnant/lactating women. This was to be directed at a selected group that was identified in a survey as being severely malnourished - for children the Harvard weight-for-age scale was used and the cut-off point was 65% of the scale or less, and for women 42 kgs weight and less was the criteria of target selection. The food supplement comprised Bengal gram and ground nut and the major objective was to raise calorie intake because it was identified as the main cause of malnutrition. After one year's intervention about 60% of the children improved their nutritional status with highest increases in the most severely malnourished group (below 50% level). Immunisation programmes taken up later also showed encouraging results with a BCG coverage in one year increasing from 0.2% of the population to 54% and DPT (2nd dose) increasing from 1.4% to 57%.

Similarly the acceptance of sterilisation for family planning increased from 45 cases in 1974-75 to 750 operations in 1975-76 in the Kasa PHC area.

Health and nutrition education, especially related to infants and children is also an important activity carried out by the PTSWs - mainly dealing with malnourishment and promotion of immunisation as well as ante-natal services.

Since the project is of an experimental nature a number of surveys and medical studies were also carried out.

**Finances :**

The project was funded by the Government of Maharashtra and supported by CARE-Maharashtra and Government of India. Details of funds and expenditure were not available but one estimate puts the per capita cost at Rs.7/- per annum for the services rendered.

## 10. DR. KASBEKAR MEMORIAL COMMUNITY VISION TRUST

**Name and Address of Project** : Dr. Kasbekar Memorial Community Vision Trust, Rasayani, Dist: Raigarh, Maharashtra.

**Project-in-Charge** : Dr. P.D. Joshi (Gen. Secretary)

This project was started in October 1979, from a generous donation given by Hindustan Organic Chemicals Ltd. This particular area was selected as the donor company was located in this area. The hospital of the company is utilised as the main referral centre by the project.

**Aims and Objectives :**

The stated objectives are : (1) cataract operations; (2) distribution of spectacles; and (3) rural health through appointment of village health workers.

The action programme around health provided an entry-point into the villages. The agency carried out a base line survey of the area at the time of the commencement of project but its findings were not made available to us.

**Social Geography :**

In its first year of operation, the project covered 16 villages in the area with the total population covered being 9775. In the course of five years, the coverage of the project has increased almost three times. Presently it covers 44 villages with a total population of 28,500. Most of the villages are located in the coastal region of Panvel Tehsil. (For population characteristics of Panvel Tehsil see profile of Kushtharog Nivaran Samiti).

The agency has indicated Agri, Maratha, Katkari and schedules castes as major communities in the project area. The main crops grown in the project area are paddy, vegetables and nachani. Out of 44, 38 villages have electricity supply and all of them have access to public transport. There are 16 private medical practitioners in the project area.

The birth rate in the area is 26 per thousand and death rate 14 per 1000 population and infant mortality rate is 124 per 1000 live births. In the first year of the project the agency identified helminthiasis, dysentry and diarrhoea as main causes of morbidity; and old age and infections in infancy as the main causes of mortality in the project population. As of now the main causes of morbidity are identified as malnutrition, helminthiasis and communicable diseases while the main causes of mortality are old age, infection during infancy and tuberculosis. In the project area the prevalence of leprosy

is 8 per 1000 population, of tuberculosis 20 per 1000 and of night-blindness 5 per 1000 population.

**Organisation and Methodology :**

The project-in-charge is a doctor. The agency had stationed one village health worker in each village covered by the project. In fact the village health workers provide them an entry point in the villages to start various programmes.

The project was started with 16 village health workers and now it has totally 44 CHWs. A doctor, nurse and a social worker provide support to the CHWs. The hospital of the Hindustan Organic Chemicals Ltd., is used as the referral medical centre. The hospital charges are fixed as per the type of illness and services rendered.

The community health workers were selected on the basis on the aptitude shown by them to undertake work, their education, age and their acceptability in the community. They were trained by a nurse and a doctor. The CHW is paid Rs.50/- per month by the agency as honorarium and Rs.5/- per week to meet their travelling expenses.

The CHWs do not render their services free. They charge 25 paise for one day's medicine from those taking treatment.

**Activities and Achievements :**

The CHWs are the chief agents carrying out the project's rural health work. Their functions include: treatment of minor illnesses; health education; care of ante-natal and post-natal cases; organisation of immunisation; collection of vital statistics and eye care and referral of cases requiring eye operation.

To work in this area is not without its own problems. The agency enumerates superstitions, ignorance, misconceptions, religious beliefs, illiteracy, poverty and malnutrition as the main problems towards fulfilling their objectives.

**Finances :**

The main source of income is stated to be the interest earned from a corpus of Rs.5 lakhs created by the Hindustan Organic Chemicals Ltd. In addition, the income is generated from the charges recovered from patients and voluntary contribution.

The agency spends Rs.66,000 per year (actual expenditure of 1983-84). Of these 53% is spent towards salaries and honorarium, 33% on medical expenses and the remaining on transport, depreciation and other administrative components.

## 11. KUSHTHAROG NIVARAN SAMITI, WAKDI, PANVEL

**Name and Address of Project** : Kushtharog Nivaran Samiti,
Gandhi Seva Mandir,
252, Swami Vivekanand Marg,
Bandra (West),
Bombay 400 050.

**Project-in-Charge** : Shri Govindrao Shinde

The project was established in 1981, the international year of the disabled, taking inspiration from existing leprosy sanatoria. With the Gandhian Sarvodaya philosophy and with the help of eminent persons in the field of leprosy the project was established in Panvel as this area showed high prevalence of the disease (8 per thousand population).

**Aims and Objectives :**

To provide vocational training to leprosy patients so that they may lead a life of dignity. To detect leprosy cases, to treat them effectively and to eradicate leprosy. To provide health education to remove stigma and fear associated with the disease.

**Social Geography :**

The project area is a tribal, hilly area in Raigad district on the western coast of Maharashtra. However, industrialisation due to proximity to Bombay, is bringing about far reaching socio-economic changes. The dominant caste in the area is Agri, followed by a large percentage of adivasis (Katkaris). Rice and vegetables are the main produce of the area.

The project villages are in the interior and sometime inaccessible areas of Panvel tehsil. The adivasis are either marginal farmers or landless labourers. In the first year the project covered a population of 37,756 in 39 villages with the help of 8 village level workers. Presently the Samiti covers 185 villages with a total population of 1,72,780. The project owns 122 acres of land on which 10,000 saplings of vegetables as well as 200 trees of other varieties have been planted in addition to 2,000 lucena trees for cattle feed; 10 acres of land is placed under paddy cultivation.

Panvel Tehsil has a population of 2,01,582 with a sex ratio of 927 females per 1000 males and an average household size of 5.3 persons. The literacy rate is 45.8% and workers constitute only 34.7% of the population and of the latter 13.5% are agricultural labourers. Tribals constitute 12% of the population.

**Organisation and Methodology :**

The project functionaries include non-medical surpervisors, leprosy and laboratory technicians and social workers. The project has 8 SET centres spread over 185 villages under its command. Eminent people from Bombay visit the project often and support it organisationally and financially. Initially 5 leprosy patients from the Dattapur sanatorium in Wardha were sent to Wakdi to help in farming the Samiti's land.

Weekly meetings are held where committee members and sympathisers of the project meet to discuss organisational matters.

The project mainly functions through the SET technique. Rejected patients are housed on the project campus. Orientation courses for students are also held where health education is imparted.

**Activities and Achievements :**

The main activity of the Samiti is treatment and rehabilitation of leprosy patients. The project has a referral centre as well as 8 government recognised SET centres and about 50 sub-centres. Vocational training is provided to patients during their stay at the sanitorium. An important focus of

the SET programme is to help in eradication of stigmatised values against leprosy so that patients are not displaced from their homes.

The project also has a massive agricultural programme. Students from cities, especially Bombay come to Wakdi for educational camps wherein they also contribute their labour towards the farms, social forestry or other strenous activity such as road construction. Students are addressed by well-known Sarvodaya and Gandhian personalities. Due to such voluntary activity, the Samiti has been able to build a good support system of sympathisers and has also become independent in terms of food grains and vegetables.

**Finances :**

Funds are received from sympathisers. Efforts are currently being made to obtain grants from the German Relief Association, Helpage as well as government sources.

Details about budgeting or expenditure were not made available.

## 12. LAXMINARAYAN VIKAS MANDAL, DAPOLI

**Name and Address of Project** : Laxminarayan Vikas Mandal,
Moreshwar Society, Ganeshkhind,
Pune 411 007

**Project-in-Charge** : Brig. N.V. Bal (retd.)

This Mandal, a public trust was started in 1967 in village Ladhghar in Dapoli taluka of Ratnagiri district. it was started by a group of persons belonging to this area on a completely voluntary basis. In 1971-72 a baseline survey was carried out in this village. The project is based on the philosophy of self-help; it discourages charity. It had to close down during the Emergency; efforts are on to revive it.

**Aims and Objectives :**

The project aims at demonstrating a model of integrated community development. Its stated objectives are : (a) to promote cultural, economic, educational and social well being and (b) to foster in the minds of society members a love of social service, sacrifice, discipline and co-operation - on the basis of field work by local volunteers, assisted as necessary by encouragement and financial support. Medical relief is also a part of it.

**Social Geography :**

The project initially began in one village but has spread its influence in numerous surrounding villages of Dapoli taluka. Dapoli is a coastal area and is quite backward. It has a literacy rate of 42.6% (33.5% female) and a sex ratio of 1310 females per 1000 males. The average household size is 4.6 persons and non-workers constitute 60.4% of the population. Of the workers agricultural labourers constitute 10% of the population and cultivators 58% - females constitute 61% of agricultural labourers and 57% of cultivators. The high feminity ratio is because of a high rate of migration of males to cities like Bombay and Pune.

**Organisation and Methodology :**

This project has no staff as employees. All work is done through volunteers. Medical relief is organised as a weekly clinic-camp with the aid of private medical practitioners from Dapoli town. All services are provided free of cost. The project that had closed down during the "Emergency" period is now being revived and meetings have been held with all Gram Panchayats of Dapoli taluka to begin a new programme with greater vigour.

**Activities and Achievements :**

In its venture for integrated community development the project runs a balwadi with 35-40 children, holds youth camps for school boys and girls, holds monthly get-togethers for the elderly and organises a weekly health clinic which has emphasis on child-care - also junior Red Cross First Aid training courses have been held for school children. However, the project admits that their efforts have so far failed in realising their objectives because the initial enthusiasm could not last long - efforts are on to revive the project.

**Finances :**

The project is funded entirely through voluntary donations, including corpus fund; also some grants from the social welfare board and the Rotary club have been received.

The corpus fund in 1982-83 was Rs.57,691.

## 13. MAHARASHTRA PRABODHAN SEVA MANDAL

**Name and Address of Project** : Maharashtra Prabodhan Seva Mandal
Vijaynagar Colony, Nilwandi Road, Dindori,
Tal: Dindori, Dist: Nasik
Nasik 422 202

**Project-in-Charge** : The Director, MPSM

Maharashtra Prabodhan Seva Mandal (MPSM) started this project in July 1983.

**Aims and Objectives :**

The stated objectives are (1) to provide medical facilities and (2) to educate people in preventing sickness.

**Social Geography :**

Nasik district has a large (24%) tribal population. Dindori Taluka, where this agency is working, has almost 50% tribal population. Dindori Taluka has no urban area and the literacy rate is only 37%.

46% of the population of Dindori Taluka are main workers while 48% are non-workers and the remaining 6% being marginal workers. Of the main workers, 51% are cultivators and 31% agricultural labourers.

The project covers 12 villages and padas having a population of 6,300. All these villages

for a continuum in the same taluka. The main castesin the project area are Mahadev Kolis (60%), Hindu Kohanas (30%), Harijans (8%) and Marathas (2%). In the project area literacy is as low as 10%. Only 4 out of 12 villages are having access to public transport. In the 12 villages, there are 2 private medical practitioners. The incidence and prevalence of tuberculosis, malaria and diarrhoea is very high, while alcoholism and unsafe drinking water are the main causes leading to morbidity.

The main crops grown are rice, nagli wheat, gram and jowar.

Lack of medical facilities in the area is stated by the project as the chief reason for its selection.

**Organisation and Methodology :**

This project does not have community health workers nor any doctor on the project. The main medical person is a nurse who has 3 assistants. The assistants are not necessarily from the villages covered by the agency. The main criteria for selection is stated to be the preference to work among the rural poor in the area where no medical facilities are available. They are paid Rs.350/- per month by the agency. A dispensary is established at village Mahaje. The health team visits different villages on foot. Medicines are dispensed to patients at cost price.

The agency has no referral facilities of its own. About 7 km away is the government health centre, with two doctors. Another government doctor does private medical practice in a village about 3-4 km away from the main government health centre.

**Activities and Achievements :**

Their activities include :

1. Providing medicines to patients
2. Educating women in sanitation, child care and nutrition
3. Ensuring clean drinking water supply
4. Educating people about the need to seggregate animals.

In the course of their work they realised that educating women in health care was necessary. So they formed women's groups to give adult education and education about maternal and child health. In these women's groups women are also explained how to make the best use of waste water for kitchen gardens. Their activities also include organising film shows and other cultural activities. The Mahila Mandal at village Mahaje runs a milk co-operative society.

The agency also helps in afforestation work; last year about 30,000 saplings were planted in the area.

The agency is trying to teach villagers to seggregate their animals from their living places but without much success. Similarly, their attempts to persuade the villagers to adopt new cropping pattern and methods of agriculture have also not brought desired results.

**Finances :**

Main source of funds is the Maharashtra Prabodhan Seva Mandal, which in turn receives funds

through donations. They spend about 70% of their budget on health and related activities. Other details about expenditure were not available.

## 14.* MATRU MANDIR, DEVRUKH, RATNAGIRI

**Name and Address of Project** : Matru Mandir, Devrukh,
Tal: Sangameshwar,
Dist: Ratnagiri

**Project-in-Charge** : Shri Vijay Narkar, Secretary

Matru Mandir was started in 1954 by Smt. Indirabai Halbe, widowed during the freedom struggle. She trained herself as a nurse-midwife and started conducting deliveries in Devrukh. When she had conducted her hundredth delivery successfully, she started a two bed maternity home with the support and encouragement of local sympathisers and freedom fighters having socialistic views. When she adopted an orphaned child many more started arriving at her doorstep and soon a small orphanage was also started. Today the two bedded maternity home has grown into a 40 bedded well equipped hospital with sophisticated operation theatres and ambulances. Through their outreach programmes, Matru Mandir has also grown beyond the hospital.

**Aims and Objectives :**

The Matru Mandir project is an overall development project with a sizeable health component - both curative and preventive. Some of the office bearers are members of political parties. The project also works in cooperation with the Lion's and other charitable groups.

The main aim of the project has been the overall care of women and children. The maternity hospital, orphanage, training centre and community health programme are all extensions of the same objective. The project's base in the villages also aims at politicisation and trade unionisation of the unorganised.

**Social Geography :**

The Matru Mandir work has spread to three talukas of Ratnagiri district - viz: Sangameshwar, Rajapur and Devgad.

Ratnagiri district, located on the coast line in south western Maharashtra receives heavy rainfall. Yet the agriculture output is very low - most farmers grow only the kharif crop. This is because the entire district is hilly and water retention is very low. The entire district lives on a 'money-order economy' with at least one member per household working outside Ratnagiri (mainly in Bombay) and sending some money back home. Land holdings on an average are too small and very few farmers can cultivate all of the land that they own. Only 2.7% of the population are agricultural labourers. Poverty is rampant, the only saving grace probably being the spontaneously growing rich seasonal fruits such as mango, cashew nut, jack fruit, coconut and so on.

The average household size in Ratnagiri is 4.9 persons and the sex ratio is 1237 females per 1000 males. The literacy rate is 48% (38% for females) and non-workers constitute 59% of the population.

**Organisation and Methodology :**

The Matru Mandir managing committee consists of five Trustees. The committee meets about 3-4 times a year. Once a year, the general body meeting is held. There are about 450 life members.

The stated objectives of the Matru Mandir project are :

1. To work for the integrated progress of women and children in rural areas of Maharashtra.
2. To establish a place for resting as well as retreat for social workers in any field.
3. To run health care centres, balwadis, hostels, social service centres, libraries and industrial training centres.

The health centres at Tamhane (Tal: Sangameshwar) reaches out to a population of 3,000; at Oni (Tal: Rajapur), which was started in 1977, to 20,000 people, and at Hindale (Tal: Devgad), started in 1978, to 5,000. People from about 100 villages utilise the facilities of the hospital in Devrukh. A full fledged 20 bedded hospital is being planned near Hindale in the memory of Dr. P.V. Mandlik, one of the founder members and trustees of Matru Mandir.

The methodology of Matru Mandir has evolved over the past 30 years when the institution started as a small lying-in maternity home. Today development programmes of the institution outweigh the work of the hospital. In three talukas Matru Mandir have tried to meet the needs of the community at the latter's doorsteps. Besides health, the project has diversified into rural development as well as organisation of people to demand their rights.

The community health programme is managed (both in Sangameshwar as well as in Oni - Rajapur) by a visiting doctor, a resident ANM and trained community health workers. The Oni centre which is 70 kms. away from the parent institution runs more or less as an autonomous project.

In addition to the hospital in Devrukh there are two dispensaries - one in Oni which is 5 bedded and the one at Hindale is 3 bedded. There are 3 full time doctors in the Devrukh hospital; these doctors visit the community health project around Devrukh, at the clinic in Tamhane village. Similarly there are 2 full time doctors at the Oni centre who visit the project area. There is one full time doctor at the Hindale dispensary. Totally the health project has 7 nurses, an X-ray technician, a pathologist and 10 health workers.

In order to treat chronic ailments indigenously, a yogic cure centre has been initiated in 1980 at Naringe village. Chronic colds and asthma are being treated here.

'Gokul', an orphanage was started in 1966 with the objective of overall development of children. Approximately 60-70 children stay in Gokul at any given time. The farms, dairy and orchards of Matru Mandir provide the food. The children are well fed and active. Individual talents are identified and developed as far as possible. An industrial training centre - mainly to train the older children of Gokul was started in 1980. The project received seventeen and a half acres of land as donation from the villagers of Sadivali village (near Devrukh) and an industrial shed was built. The machinery was donated by a German funding agency. An engineering firm from Pune offered technical expertise for the training.

24 acres of hilly land has been bought by Matru Mandir and has been converted into farms and an orchard. The produce is used for the Gokul children and surplus sold in the local market.

**Activities and Achievements :**

The Devrukh hospital besides providing medical care offers immunisation services and organises surgical (free or subsidised) and diagnostic camps periodically with the financial support of sympathisers and organisations such as Lion's and Rotary clubs. The project also runs a medical store within the campus of the Devrukh hospital. Medicines are given on a credit basis to needy patients.

The community health programme of Matru Mandir is based in three talukas of Ratnagiri. Each centre has a dispensary where full time doctors reside. Trained ANM as well as community health workers (many of them are traditional dais trained by Matru Mandir to be CHWs) reside in the villages of the project area. Conducting deliveries, general MCH care and treatment of common ailments is the main thrust of the programme. Periodically a health check up - specially of children and women is held. Health cards are issued so that under 5 children as well as pregnant women's health can be monitored.

The orphanage is only a residential institution. Children attend local schools and upto the age of 18 years are supported through government grants. After the age of 18, the 'Gokul Rehabilitation Centre' offers technical and industrial training. Many of the children have received training as teachers, nurses and training in sewing and other arts. 'Gokul' also takes the responsibility of marrying off the grown up girls. Job opportunities for the children of 'Gokul' were created by persuading an engineering firm to start their machine manufacturing at Devrukh. 80 workers are employed in this unit. 6 children from 'Gokul' have been absorbed on the agricultural farm of Matru Mandir and some others have found employment within the Matru Mandir hospital itself.

To encourage the latent talents of children, various competitionsare held periodically. Artists and athletes are identified and looked after individually. Sponsorship is arranged for children who desire higher education. Children are sent to camps outside Ratnagiri - Bombay, Delhi, Goa and such places to create self confidence.

A reading library (Sane Guruji Bal Vikas Kendra) was started in 1960 with a collection of 5,000 books. It is used by children regularly.

Matru Mandir also runs 26 balwadis in 4 tehsils - Sangameshwar, Rajapur, Devgadh and Malvan. About 1000 children benefit according to the project report of 1982-83. Since 1978 all children in the balwadis are given supplementary nutrition.

In the field of agriculture Matru Mandir provides technical expertise and training to farmers in modern cultivation methods. Matru Mandir also helps artisans through a small centre that trains them and provides financial assistance.

Matru Mandir has got involved in economic and agitational issues of the local population. A fishermen's society has been started in Munge village. In Oni, the silica workers are organised by the project. Under the EGS, Matru Mandir has mobilised people to organise and reach roads to inaccessible villages. A Milk Producers' Society has also been started at Oni. Loans are given to farmers to buy milch cattle. The collection and marketing of the milk is managed by this cooperative society.

Electricity was reached to local villages in Sangameshwar taluka. Farmers were given loans, legal advice and assistance whenever required. Problems related to drinking water are also taken up by the Matru Mandir in their project area.

Under their rural development programme, students from colleges (even from Bombay) are taken for camps to their project villages under the NSS scheme. They are introduced to rural needs and problems and in turn they offer 'Shramdaan' for fifteen days in any of the rural project areas of Matru Mandir.

**Finances :**

According to their 1982-83 report, the entire budget of Matru Mandir was Rs.20 lakhs and of this health services accounted for Rs.6.5 lakhs. Educational activities amounted to Rs.4 lakhs.

OXFAM contributed Rs.50,000 for the health project and for agricultural activities. The Maharashtra Government (Social Welfare Department) pays Rs.60 per child per month for all children below eighteen years of age in 'Gokul'. The West German agency DW makes up for the deficit funds for running 'Gokul' by sponsoring children. The expenditure of the balwadis, creches and the nutritional programme in balwadis is funded by the Bal Vikas Samiti (Maharashtra Government). The rest of the funds (amounting to not more than Rs.5,000 per year) are collected from individuals and trusts. The Dr. P.V. Mandlik Memorial Trust has agreed to build a full fledged hospital in Hindale village for the Matru Mandir.

## 15. RAJMATA JIJAU PRATISHTHAN

**Name and Address of Project :** : Rajmata Jijau Pratishthan,
Jyoti Sadan, Sitladevi Temple Road,
Mahim, Bombay.

**Project-in-Charge** : Trustees

The Pratishthan is a public trust that was established in the early seventies. The purpose of establishing the trust was to build up a network of rural hospitals all over Maharashtra, at least two in every district. The first Jijamata Hospital with an 80 bed capacity, was established in 1975 at Vashi and this was followed by two 25 bed hospitals at Alibag (Raigad) and Sindkhedraja (Buldhana) in 1977 and another at Oras (Ratnagiri) in 1981, the last one being an ayurvedic hospital. The trust is backed by Mrs. Shalini Patil, a well-known politician.

**Aims and Objectives :**

The primary aim of the Pratishthan is setting up of a chian of Jijamata Hospitals in rural areas all over the state. The focus of activities of each of the hospitals, besides providing curative services, is to promote family planning.

**Social Geography :**

The Pratishthan's activities are state wide. Among the four districts covered so far, Thane and Raigad are developed areas, whereas Buldhana and Ratnagiri are backward.

**Organisation and Methodology :**

The project is entirely hospital based with no outreach activities except for family planning camps and a few medical camps. The hospitals are under the care of a medical superintendent. Each

hospital has its own management committee constituted of the senior staff, local private doctors and prominent social workers. The hospitals are minimally staffed, having visiting specialists who visit on fixed days.

**Activities and Achievements :**

The hospitals are routine curative centres providing medical care to those who can manage to get there; a patient has to pay for the service at rates similar to those changed by private insitutions that run as public trusts. Occasionally medical and family planning camps are held in surrounding villages.

**Finances :**

Information not available.

## 16. RAMAKRISHNA MOBILE HOSPITAL

**Name and Address of Project** : Dr. Mhaskar Medical Foundation, Amalner, Dist: Jalgaon

**Project-in-Charge** : Dr. P.R. Mhaskar

Ramakrishna Mobile Hospital is a project of the Dr. Mhaskar Medical Foundation, established in 1980 by the Mhaskar family in Amalner. From the beginning of this century to the establishment of this Foundation, 8 doctors from the Mhaskar family have worked in this area through their hospital founded in 1907 and by organising medico-surgical camps in tribal areas. Activities of the Ramakrishna Mobile Hospital in its present form were started from 1978.

**Aims and Objectives :**

The stated objectives of the Ramakrishna Mobile Hospital are as follows :

1. To reach benefits of medical examination, consultation and treatment to villagers.
2. To perform operations like appendicitis, toncillitis, hernia, etc.
3. To undertake ENT and optic surgery.
4. To reach medical squads for help in times of accidents, floods, epidemic and other natural calamities.
5. To impart knowledge using visual aids about preventive methods and sanitary living.
6. To organise research in diseases and their prevention.
7. To give young practising doctors an insight in treatment and surgery and try to motivate them to render selfless service even while doing private practice.

**Social Geography :**

The basic approach is to provide medical care by organising camps at different places. The agency organised camps in Dhule, Nasik, Ahmednagar, Pune and Satara districts. In addition, their mobile hospital caters to the area around Amalner and other places in Jalgaon district.

Their reports mention that their target population is tribal and other rural population, although some of the camps were organised in taluka centres (e.g.: Sangamner, Sirur, etc.) and also in bigger towns or cities (e.g. Pimpri-Chinchwad, etc.).

**Organisation and Methodology :**

The agency is governed by a seven member managing body, four of them belonging to the Mhaskar family. Amongst remaining three members, there is a lawyer, a journalist and a writer.

The staff is led by Dr. P.R. Mhaskar who is the medical officer and surgeon of the mobile camps. Another doctor in the team is his wife. In addition, there are two senior and two junior nurses and two compounder-cum-dressers. Non-medical staff consists of an electrician, an accountant, a driver and a cook.

The camp is organised in a village for 4 to 8 weeks. The village is selected by an advance probing party on twin considerations of need of the local people and willingness of local agencies to co-operate. The work of the camp is divided into two sessions. In the first session lasting for two weeks, the staff moves to adjacent villages to inform people of what services the camp will be providing, to discuss about prevention of diseases and imparting health education through visual aids. In the second session, starting after the completion of the first, curative medical and surgical care is provided. The agency makes special efforts to involve local private medical practitioners in the work of the camp. The patients are charged for the services rendered.

**Activities and Achievements :**

The chief activity of the project is organising medico-surgical camps. From 1977 to 1982, the agency organised 27 such camps in different districts of Maharashtra. In these camps they performed altogether 271 major operations and 4625 minor operations.

**Finances :**

The agency has acquired a scrap S.T. bus (passenger bus) costing Rs.2,15,000 in 1978 and converted it into a mobile operation theatre. The agency has spent totally Rs.3 lakhs (including bus) as capital expenditure for the mobile hospital.

No detailed income/expenditure accounts are available, but the average expenditure for each camp as estimated by the agency, comes to Rs.32,700/-, as compared to the total estimated income of Rs.25,600/-. The agency estimates a deficit of Rs.6,000 to 8,000 per camp which is spent by the Mhaskar hospital.

## 17. SKIPPO PROJECT OF AIWC

**Name and Address of Project** : Skippo Project of the All India Womens' Conference,
C/o Smt. Kesarbai Bhimai Working Women's Hostel,
Vithal Nagar Society,
12th N.S. Road, JVD Scheme,
Bombay 400 049

**Project-in-Charge** : Chairperson, Skippo Committee

The Skippo project was started in 1946 when the AIWC-Bombay branch received a medical van as a donation from a British woman to provide health services to a rural population. In 1946 a health unit at Talasari in Thane district was started alongwith a mobile unit.

**Aims and Objectives :**

The AIWC runs various programmes and the health project at Talasari is one such programme which is aimed at providing medical care to the under-privileged sections for whom medical services are inaccessible.

**Social Geography :**

Talasari is an almost totally tribal taluka with tribals constituting 91% of the population. Talasari is politically a very volatile area and has a number of voluntary agencies and activitists engaged in various kinds of activities. The average household size in this taluka is 5.7 persons and the sex ratio is 1043 females per 1000 males. The literacy rate is 11.8% (3.4% for females) and non-workers constitute 44.5% of the population. Of the workers 15% are agricultural labourers.

**Organisation and Methodology :**

The AIWC has a sub-committee on health which runs the Talasari health project. It has a dispensary with maternity and general wards located at Talasari. There was also a mobile van that provided village extension services but has been discontinued since 1977. The dispensary for the last thirty five years has been run by a doctor-nurse couple; the doctor has now retired and the centre is run by the nurse-midwife. No outreach programme is currently in operation.

**Activities and Achievements :**

The main activity of the project is medical relief which it provides through its dispensary and until a few years ago also through a mobile team. It is a purely curative service project with no effort towards establishing community health services. In 1982 a total of 12,212 patients were treated and out of these 65% were for skin diseases, 19% for malaria and 14% for diarrhoea and dysentry; eight deliveries were also conducted.

The project as of recently has started Mahila Mandals and Balwadis in a few villages.

**Finances :**

The project is funded mainly through donations. In the year 1980-81 the project's expenditure was Rs.20,742/-, out of which salaries constituted 37% and medical expenses 26%; the remaining part covered administrative and transport costs.

## 18. WADA RURAL PROJECT OF FPAI, THANE

| | | |
|---|---|---|
| **Name and Address of Project** | : | Wada Rural Project, FPAI,<br>Gopal Kunj, Parali Naka,<br>Tal: Wada, Dist: Thane. |
| **Project-in-Charge** | : | Project Co-ordinator |

The FPAI is a large organisation with a network of experimental projects all over the country. The Wada Rural Project is one such project in which FPAI has linked its family planning activities to rural development programmes of the government. This project was started in 1979 by FPAI and works in collaboration with Aspee Agricultural Research and Development Foundation, Bombay Chamber Rural Development Foundation, R.J. Mehta Free Trade Unions' Multipurpose Trust and Dhanvantri Public Charitable Trust. In other words, it is a project having active support of the corporate sector. All these agencies cover 5 different backward and mainly tribal talukas of Thane district. The major focus of all these projects is population control.

**Aims and Objectives :**

The main objective of the Wada Rural project of FPAI is to integrate family planning with social and economic development activities so as to enhance the health, family planning and educational status of the people of this area. With a view to achieve this objective an effort is made to support voluntary action for the overall progress of the community at individual, family and community levels and to link up this effort with acceptance, adoption and promotion of the small family norm.

It's operational objectives are :

1. To integrate family planning activity with rural development activities supported by the government and other agencies;
2. To encourage community action for family betterment;
3. To create awareness through education about the population situation and the need for adoption of a small family norm;
4. To educate and motivate eligible men and women for acceptance of suitable family planning methods;
5. To encourage acceptors to motivate other eligible persons for spacing and limitation; and
6. To establish voluntary village committees to support project activities.

**Social Geography :**

The project covers 80 villages of Wada block which is a backward and hilly area; half its population constituting tribals. Wada taluka has a population of 95,652 spread over 16,793 households making for an average household size of 5.69 persons and a sex ratio of 981 females per 1000 males. Tribals constitute 51% of the population of the taluka. The literacy rate is 38% (27% for females), but among the tribals it is 15.4% (6% for females). Non-workers constitute 52% of the population (45% amongst tribals) and agricultural labourers 36.6% of the workers (53% amongst tribals).

**Organisation and Methodology :**

At the apex of the project is a co-ordinator who operates from FPAI headquarters in Bombay under a liaison committee. In the field there is a field organiser with a battery of field workers. The field staff functions through villages as units where they organise people into Youth Clubs and Mahila Mandals and operate their programmes through them. However, the approach is a top-down one. The project co-operates with various private and government agencies in implementation of its programmes. The project by itself does not have a health programme but in association with the Dhanvantari Public

Charitable Trust and R.J. Mehta's Free Trade Unions Multipurpose Trust organises medical camps, as also school health camps in collaboration with the Parali PHC.

**Activities and Achievements :**

For realisation of its objectives the project carries out educational (family planning) activities, social and developmental activities, income generating activities and family planning and MCH activities.

Education geared towards promoting a small family norm is carried out by the field workers through personal counselling, group meetings, film shows, posters, camps and seminars. Also information about other welfare programmes of the government is given.

Among its developmental activities are included social forestry, adult education, infrastructure development and promotion of savings schemes.

Under its income generating activities a few villagers have been assisted in purchasing buffaloes, establishing pottery making units and agricultural improvement programmes through various government schemes.

The family planning programme is the most important activity. It is promoted through educational campaigns and the MCH programme through which pregnant women are motivated into accepting family planning. The main thrust of the family planning programme is organising camps for sterilisation. Till 1981, vasectomy and condoms accounted as main methods, but in 1982 with the use of laproscopes, tubectomy has become the main method of acceptance for family planning. The project has also motivated many local institutions to start balwadis. Currently 14 balwadis are operating entirely through local constributions.

**Finances :**

In 1982 the project's expenditure on various village programmes (excluding family planning, staff salaries, administration and transport, that comes from the corporate sector) was Rs.15,149 out of which the community contributed 73% and the FPAI only 15%. Details about other expenditures was not available.

## 19.* YUSUF MEHERALLY CENTRE - PROJECT, TARA

**Name and Address of Project** : Bombay Office :

National House, 6, Tulloch Road,
Apollo Bunder,
Bombay 400 039

Project

Village Tara, Near Panvel
Dist: Raigarh

**Project-in-Charge** : Dr. G.G. Parikh

This centre was set up on May 1, 1962 in the memory of Yusuf Meherally - a freedom fighter, youth leader and a great humanist. Initial efforts of the centre were concentrated on stimulating fresh thinking on diverse social problems through seminars, lectures, printed literature and exhibitions. In 1967,

on the initiative of a member having a farm house in village Tara a Sunday clinic was established. A team of doctors from Bombay would go there every Sunday and the approach was more charitable than that of working for social change. Organisations like Lions Club and others were also involved in these activities. By 1978, the Sunday clinic grew into a dispensary and from that into a 30-bed hospital.

Some of the important office bearers of the agency are members or sympathisers of the Janata Party.

**Aims and Objectives :**

In their published literature, the broad philosophy of their work is explained as follows :

They believe that our villages need to be made self-sufficient.

The villagers must be helped to help themselves. An organisation based in a metropolitan area can develop a nearby rural area.

To this end, the centre has sought to mobilise resources and talents of all those who feel concerned about rural development. In its task it seeks to involve not only the local community but all who feel a concern for the poor and the underprivileged.

Some of the objectives stated in their pamphlets are :

1. To set up a new hospital;
2. To intensify afforestation programme;
3. To strengthen the infrastructure of the villages; and
4. To generate more employment opportunities by expanding the scope of the village industries programme.

**Social Geography :**

They cover 20 villages having a population around 15,000 in a triangle formed by Panvel, Pen and Rasayani in Raigarh district. A socio-economic survey was conducted under the guidance of the Gokhale Institute of Politics and Economics, Pune in 1975. The findings reveal that in the project area, 48% of the land is cultivable (10% is arid and 35% is forest land). Only 10% of the land is under irrigation and 7% bears a double crop. The major crop is paddy. The landownership distribution is similar to that in most backward areas. Adivasis and Harijans own little or no land and live in separate 'padas'. There are no village industries; banking facilities only came when the centre persuaded the Union Bank of India to open a branch in it's own premises.

Panvel taluka, in which probably all village covered by the project are located, has 20% urban population. Being not very far from Bombay, the trend of urbanisation is likely to continue and may increase. 11.8% of people are tribals in this taluka while only 2% are of scheduled castes. About 46% population is literate but amongst literates only 35% are women. This taluka has 35% working population and out of them only 13.5% are agricultural labourers. 61.1% of people are in non-working category. Women's employment appears to be very poor as out of the total female population, 76% are non-working as per census definition.

**Organisation and Methodology :**

The apex body of the organisation is a managing committee consisting of 16 elected and 5 nominated members. At the field centre in village Tara, the agency has a project director and activity in-charge who supervise and plan the activities of the project.

The centre has a village adoption scheme. Various organisations are encouraged to adopt one or more villages. In the field of health, they have village health workers in five villages and thus community health approach is not the dominant component. Instead more emphasis is given on the mobile clinic with a doctor accompanying it.

In the socio-economic field the project has set up village industries (power-ghani, carpentary workshop, bakery, soap making unit, etc.) which provide employment as well as training to people from the villages. In addition, the project's social workers as well as other activists not affiliated to the project organise the poor people for both political agitation as well as for constructive work.

Afforestation is also a very important component of the project. They have a plant nursery that is run with the help of the local community. With some assistance from school children from Bombay 10,000 saplings were planted in 1982 and care was taken in ensuring the survival of 80% of these plants.

The project has undergone many changes since it started in 1967. Though the entry point was medical camps and distribution of free medicine by doctors from Bombay visiting Tara every Sunday, they soon realised that by such an approach they were creating more dependency. They had no outreach programme to help villagers. Thus evolved socio-economic programmes which now constitute the main activities while health programmes have not grown to the same extent. This becomes clear from the fact that only five villages have community health workers. The other health programmes are more hospital based (such as diagnostic and operation camps).

**Activities and Achievements :**

In the last 18 years the agency has treated 2,25,000 patients, restored eye sight to about 3000 blind and nearly blind, dug wells in three villages and repaired wells in more than six villages, repaired roads in all villages covered, helped in electrification and so on. It has provided huts to about 80 families in three villages. It has planted more than 200,000 trees.

The agency motivated 10 families to install gobar gas plants. The workshops and village industries of the agency give training and employment to the people in the project area.

The agency's future plans include :

1. Setting up a reference library and documentation centre (in the Bombay office);
2. Dairy development and setting up a chilling plant;
3. Vocational training centre for dropouts and handicapped children; and
4. Extension of village adoption scheme to new villages.

**Finances :**

Their donors include Rotary Club of Bombay; the International Year of the Child Committee; the Dusseldorf, West Germany; the Lions Club Juhu; the Royal Commonwealth Society for the Blind.

Apart from that they get donations from members, sympathisers and industrial houses.

Their annual financial requirement is almost Rs.12 lakhs out of which half is the working capital required for the workshops and village industries run by the agency. Other details of their finances and expenditure were not available.

## MARATHWADA REGION


Marathwada constitutes the central territory of Maharashtra and includes the districts of Aurangabad, Bid, Osmanabad, Parbhani, Jalna, Nanded and Latur. The region as a whole is highly backward and seethes under caste-conflict, especially between marathas and the scheduled castes. Historically this region was part of the erstwhile Nizam state.

## SOCIAL, ECONOMIC AND HEALTH INFORMATION, MARATHWADA REGION DISTRICTS

| Districts | Population (Persons) 1981 | Urban Popuin. (Percent) 1981 | % Area of State 1981 | Density per km. (Persons) 1981 | Average Household Size (Persons) 981 | Popuin. Growth 1971-81 (Percent) | Literates (Percent) 1981 | Female Literacy (Percent) 1981 | Sex Ratio (F/1000M) 1981 | SC Popuin. (Percent) 1981 | ST Popuin. (Percent) 1981 | SC as % of State 1981 | ST as % of State 1981 | No. of Villages |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Aurangabad (include Jalna) | 2433420 | 22 | 5.3 | 149 | 5.54 | 23.46 | 35.80 | 19.96 | 947 | 6.18 | 3.11 | 3.36 | 1.31 | 1959 |
| Parbhani | 1829378 | 19 | 4.1 | 146 | 5.41 | 21.41 | 30.33 | 15.53 | 968 | 5.82 | 4.30 | 2.38 | 1.36 | 1615 |
| Bid | 1486030 | 15 | 3.6 | 134 | 5.48 | 15.54 | 131.79 | 17.27 | 966 | 11.47 | 0.90 | 3.81 | 0.23 | 1256 |
| Nanded | 1749334 | 19 | 3.4 | 167 | 5.67 | 25.15 | 29.78 | 15.67 | 960 | 11.30 | 10.19 | 4.41 | 3.09 | 1425 |
| Osmanabad (includes Latur) | 2230620 | 15 | 4.6 | 157 | 5.78 | 17.61 | 35.36 | 21.40 | 958 | 15.35 | 2.33 | 7.63 | 0.90 | 1527 |

| Districts | CMIE Index Score 1980 | Main Workers (Percent) 1981 | Non-Workers (Percent) 1981 | Agricultural Labourers as % of main workers 1981 | Sex Ratio of Agric. Labourers F/1000 M 1981 | Ratio of Agric. Labourers to Cultivators(Percent) 1981 | % Main workers in Non-Agricultural sector 1981 | Average Size of Operational holding (hectares) 1976-77 | Per Capita Production of Food Grains (Kgs) Avg. of 1975-1980 | Avg. Daily Employment in Factories (Per 1,00,000 population) 1977 | Per Capita Bank Deposits (Rs.) 1983 | Per Capita Bank Advances (Rs.) 1983 | % Forests Area (Percent) 1973-74 | % Villages Electrified (Percent) 1984 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Aurangabad (includes Jalna) | 90 | 41.2 | 54.7 | 31.36 | 1150.0 | 68.55 | 23 | 4.6 | 210 | 1039 | 399 | 373 | 5 | 100 |
| Parbhani | 62 | 44.3 | 50.6 | 40.08 | 1038.7 | 101.25 | 21 | 4.7 | 233 | 196 | 175 | 151 | 3 | 85 |
| Bid | 62 | 40.4 | 54.0 | 31.20 | 1079.3 | 65.43 | 21 | 4.5 | 270 | 733 | 183 | 137 | 2 | 95 |
| Nanded | 63 | 40.6 | 50.6 | 36.93 | 1030.4 | 92.01 | 23 | 4.0 | 211 | 416 | 227 | 201 | 8 | 100 |
| Osmanabad (includes Latur) | 65 | 38.9 | 55.1 | 38.13 | 940.1 | 90.39 | 20 | 5.4 | 275 | 113 | 189 | 152 | 1 | 100 |

| Districts | Voluntary Hospitals 1979 | Govt.& Local Body Hosp. 1979 | P H C S 1983 | P H C S 1984 | Rural Hosp. 1984 | B C G Vaccination 1983-84 | DPT Vac. 1983-84 | Polio Vac. 1983-84 | T.T. Mothers 1983-84 | T.T. Upto 16 years 1983-84 | Tubectomy 1983-84 | Vasectomy 1983-84 | IUDs 1983-1984 | Estimated Eligible Couples 1983-84 | Couples Currently protected by 1983-84 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | Steri-lisation | IUCD | Other Method |
| Aurangabad (includes Jalna) | 17 | 22 | 20 | 70 | 6 | 208720 | 125608 | 70503 | 69519 | 61078 | 19289 | 4519 | 37963 | 466000 | 148610 | 31638 | 17247 |
| Parbhani | 15 | 4 | 14 | 44 | 3 | 77847 | 85616 | 42826 | 47900 | 45930 | 9750 | 1793 | 26086 | 320000 | 118632 | 21587 | 11608 |
| Bid | 4 | 4 | 12 | 41 | 4 | 50558 | 63976 | 18752 | 38885 | 31802 | 11091 | 760 | 24728 | 262000 | 104824 | 19698 | 11036 |
| Nanded | 7 | 5 | 14 | 48 | 5 | 65055 | 94915 | 38446 | 53500 | 35750 | 8538 | 1164 | 19792 | 340000 | 94005 | 15978 | 15575 |
| Osmanabad (includes Latur) | 8 | 8 | 17 | 74 | 5 | 92368 | 116053 | 60194 | 97250 | 57740 | 21181 | 1585 | 37580 | 421000 | 141580 | 29718 | 16241 |

Sources : Compiled from :

1. Census of India: 1981, Series - 12, Maharashtra, Primary Census Abstract Part II-B, Govt. of Maharashtra, Bombay, 1983.
2. Profiles of Districts, Part I : A-K, Part II : L-Z, Centre for Monitoring Indian Economy, Bombay. 1985.
3. Performance Budget, 1985-86 - (a) Family Welfare, (b) Medical (Non-teaching Hospitals), (c) Public Health and Sanitation, Government of Maharashtra, Aurangabad, 1985.

## 20.* COMPREHENSIVE HEALTH AND DEVELOPMENT PROJECT, PACHOD

**Name and Address of Project** : Ashish Gram Rachna's
Comprehensive Health and Development Project,
Pachod, Tal: Paithan
Aurangabad

**Project-in-Charge** : Dr. Ashok Dayalchand

The Pachod project in its present form was initiated in 1977 before which a baseline survey of 72 villages of Paithan taluka was undertaken. It was converted into a trust in 1978. In its first year it covered 12 villages having a population of 15,000. It sought government collaboration to implement a community health scheme but within two years the scheme functioned independent of the government health structure.

The project has primarily an MCH service orientation, and its main and perhaps unique feature is its exercise in conceptual formulations prior to undertaking any programme implementation : a series of conceptual exercises are undertaken to understand the possible social consequences of putting an idea into action. If the idea seems feasible, the new intervention strategy is tried out on a pilot basis in order to understand the practicability and contradictions of the methodology.

Presently (1982-83) the project's community health programme serves 37 villages having a population of 43,000.

**Aims and Objectives :**

Originally the project aimed at collaborating with the government to demonstrate that within close proximity of the existing infrastructure an effective methodology could be evolved for providing adequate health to a representative population; through innovative practices and reallocation of personnel and material resources health care delivery could be made more effective and accessible to the most underserved population.

With the withdrawal of government collaboration the project became independent to demonstrate an innovative methodology which presented a deep contrast to the government system. As declared by the project, the aim is to test the validity of an organizational scheme wherein the maximum emphasis is placed on peripheral feedback and follow-up, rather than on the expansion of the existing system. It is aimed to place maximum emphasis on feedback through village based health workers, specially trained for this work and to implement both curative and preventive programmes.

Recently the project has furthered its research orientation by adding the objectives of :

(a) research in various aspects of rural health care;

(b) establishment of various norms related to health practices; and

(c) development and evaluation of innovative concepts and methodologies for the health delivery system.

The initial operational objectives were as follows :

(1) Reduction in birth rate from 36 to 25 per 1000 in four years.

(2) 50% reduction in IMR and under-five mortality in four years.

(3) 50% reduction in malnutrition in four years.

(4) Effective ante-natal and post-natal care and immunization against tetanus for 80% of the pregnant mothers in two years.

(5) 80% control of xerophthalmia in one year; treatment of 80% of the existing cases of blindness among patients with curable eye diseases.

(6) To bring under control and treatment 80% of the tuberculosis and leprosy cases in four years.

(7) In service training for indigenous dais and for CHWs.

(8) Regular health education programme in all villages of the project area continuously for four years.

**Social Geography :**

The project is located in Paithan taluka of Aurangabad district. This area was selected because the project holder was already working there since 1974 in a Protestant mission hospital which has been there since fifty years.

In recent years Paithan taluka has developed at a fast pace. Firstly because of the Jayakwadi dam that has provided ample irrigation, and secondly because Aurangabad is probably the fastest expanding industrial city in Maharashtra.

It is still an area seething with caste/community conflicts. In the project area among the Hindus who constitute 72% of the population, 59% are Marathas and 5% Harijans. Besides the Hindus there are Muslims (13%) neo-Buddhists (11%) and Christians (3%) - the latter two also constitute scheduled castes alongwith the Harijans. The literacy rate is estimated at 31% and landless agricultural labourers constitute 30% of the working population. The crude birth and death rates are estimated at 32 and 10 per 1000 population, respectively, and the IMR is 105 per 1000 live births (1982-83).

Paithan taluka has a population of 1,86,851 spread over 35,282 households giving an average household size of 5.29 persons. The sex ratio is 970 females per 1000 males and the literacy rate 33.7% (17.5% females). Non-workers constitute 51.3% of the population, agricultural labourers 38% of all workers (57% females) and cultivators 42.6%. Almost all the villages have electricity supply (but only 10% of the households have electricity connections) and at least a primary school. As of present most farmers take a single food crop (jowar) but as availability of irrigation increases, double cropping increases and there is a shift towards cultivation of cash crops such as cotton, sugarcane and groundnuts. The transport and health services infrastructure is also fairly well developed; Paithan taluka has two existing PHCs (one of them as good as being non-existent) and four were to be added in 1984. There is one cottage hospital and one municipal dispensary - a unit of the Aurangabad Medical College; the latter is also within easy reach of the project villages.

**Organisation and Methodology :**

The organisational structure is three-tier. The base centre is at the Pachod hospital and at the grass roots are village health posts held by CHWs and trained dais. In between is the mobile team covering each village every fortnight. The hospital is 30 bedded and has adequate medical facilities. It is a referral unit for the project villages as also a service centre for the general population. It works on the basis of fee-for-service but has a differential rating system directly proportional to the economic

status, and an informal priority for treatment of cases referred by a CHW or dai (with 50% deduction in charges).

The village health posts are run by trained dais and/or CHWs for two to three hours every fortnight. Presently in its 37 villages, there are 25 CHWs and 30 trained dais. The concept of health post was developed to avoid the impression that health care is being imposed (as in the case of house to house visits) and secondly to create an informal group situation where through the mode of "gossip" knowledge of new practices could be passed on and relevant social issues discussed. This was aimed at evolving a system of group pressure for the positive acceptance of the project's programmes as well as for internalisation of values for which the project stands.

Most CHWs and dais (90%) are from the backward class/caste. Most of the CHWs and dais as a consequence are also illiterate. These women were selected primarily because of their greater mobility. The CHWs received an initial training of one month and now receive a continuous fortnightly in service training. The project pays them a stipend of Rs.50/- per month.

The mobile team consisting of ANMs and MPWs provide a support to the CHW and dais. The ANMs conduct ante-natal and post-natal clinics and immunisation. The MPWs impart nutrition education and record child growth.

The project has probably the best data recording and maintenance system among all projects studied. There is a full-time demographer responsible for this; what is unique is that the basic reporting system has been evolved by the dais and CHWs through symbols representing all their activities.

The project also has a nutritionist who forms the core of the MCH programmes. She monitors the field programmes, provides in service training and is responsible for all actions under the MCH and nutrition programme as well as for the efficiency of the dais, CHWs, ANMs and MPWs.

The entire strategy of the community health programme rests on the theoretical assumptions of "small-groups" - that objectives can be realised through generation of ideas for change or demonstration of action for change in an informal group situation. Thus, group dynamics becomes an effective tool towards strengthening the value of action programmes and introduction of new concepts. However, the project staff insists that change in beliefs, attitudes and practices must be initiated not through challenge from a new sphere of knowledge but by introducing the new knowledge within the framework of traditions and well established beliefs. They believe that contraditions hurt the sentiments of the community leading to conflicting values and therefore non-acceptance and apathy towards it by the community. New knowledge must substantiate and rationalise, and not contradict existing beliefs.

**Activities and Achievements :**

The mainstay of the community health project are its MCH activities. Through dais and CHWs ante-natal services and hygienic delivery practices have been popularised. In the first year of coverage (1977-78) 57.5% of expected deliveries were registered through ANMs but in 1981-82 this increased to 73.5%; and of all ANC registration 60% were registered before reaching 24 weeks of pregnancy in 1981-82 as compared to 48.2% in 1977-78. Further, pregnancy wastage (abortions) declined from 28.9 per 1000 live births in 1977-78 to 9.7 per 1000 livebirths in 1981-82, and infant mortality rated from 115.6 to 78.9 per 1000 live births. (These rates refer to the segment of population receiving MCH services).

The CHWs and/or dais also provide simple curative services for a nominal cost (50 paise to Rupee 1 for a day's medicine). The nutrition education programme and child health care is also an important component. Child growth is carefully monitored and malnutrition status determined. Though third degree malnutrition has declined considerably, this programme has not shown expected results; this is due to the fact that poor economic conditions are a barrier difficult to circumvent in the absence of economic development.

Besides health care various related socio-economic programmes have been undertaken from time to time, mostly on an experimental basis. For instance, mothers who suffered from complete failure of lactation were included in the goatery programme. A balwadi was started in one village where the people found it to be a felt need. Each child was charged Re.1/- per month and various health practices were promoted through it. All parents had to meet once a week and the consequence of this was the formation of a strong peer-group which decided to organise itself into a farming collective. This posed a threat to the existing leadership and events that followed forced the abandoning of this programme. Efforts have also have been made to assist villagers in taking advantage of the government's IRDP schemes. Afforestation and "social forestry" to help landless labourers and marginal farmers have been undertaken. Bio-gas plants are also being constructed as an alternative source of energy.

The project undertakes research to learn about health and related social issues as well as to test, evaluate and provide a self-critique of its programmes. The project is planning to provide consultancy and evaluation services through a project funded by OXFAM.

**Finances :**

The project is entirely funded by OXFAM. In an evaluation study by OXFAM the 1979-80 expenditure was Rs.2,80,230; out of this 7% was spent on ANC/PNC; 27% on child care, nutrition, immunisation and minor ailments; 14% on mass health education; 13% on survey, evaluation and monitoring; 20% on administration, 4% on self-education; 10% on government co-ordination and 5% on training of CHWs. The per capita cost worked out to be Rs.5.60.

Information supplied for the latest year (1981-82) reveals that the total expenditure was Rs.3,45,000 working out to Rs.8 per capita; out of this 53% was spent on staff salaries; 17% on transportation; 21% on stipend, and supplies and drugs to village workers; 6% on administration and 3% on printing etc. It must be noted that the project also generates its own resources through hospital services and recovery of medicine cost from villagers themselves.

## 21. KAYADHU RURAL DEVELOPMENT PROJECT

**Name and Address of Project** : Kayadhu Rural Development Project,
Post: Nandapur (S.C. Rly),
Tal: Kalamnuri,
Via: Purna 431 511
Dist: Parbhani

**Project-in-Charge** : J.P. Paikrao

Kayadhu Gram Vikas Pratishthan, Nanded, runs the Kayadhu Rural Development Project in Kanjara. This project was started in 1983 by a group of people from Nanded and Parbhani district.

**Aims and Objectives :**

The stated objectives of the project are :

1. To raise socio-economic and political awareness among the poor in the project area;
2. To create confidence and self-reliance attitude among beneficiaries;
3. To create a co-operative spirit;
4. To involve women in the development process, to organise, train and develop women's leadership potential, to take up issues of women in particular and society in general;
5. To undertake, execute and assist programmes for the improvement of socio-economic, health, education and cultural conditions of the weaker sections of the community;
6. To encourage and develop leadership of youth and motivate them to work for the benefit of the community and;
7. To undertake, execute and assist training programmes in agriculture, self-employment, technical, veterinary, health, dairy farming and animal husbandry.

**Social Geography :**

The project covers 6 villages in the southern part of Kalamnuri taluka of Parbhani district. This area is covered in the north by the Kayadhu river, in the south and east by rocky hills while the western side is plain land. It is a semi-arid area with annual rainfall being between 500 and 600 mms. Major crops grown are jowar, wheat, bajra, rice, groundnut, karadi, til, sunflower and cotton. Varieties of pulses are also grown.

75% of land is single crop land while in the rest, two crops are taken. Irrigation is mainly from wells while there are a few lift irrigation pumps drawing water from the Kayadhu river.

In the project area literacy is very low, only 5% of women are literate. Untouchability and inferior treatment to lower castes are highly prevalent. The nearest government health centre is about 35 km. from the project villages. The main medical problems of the people as identified by the agency are scabies, TB, leprosy, diarrhoea, malaria, whooping cough and malnutrition.

The agency selected this area as it is very backward, people from socio-economically lower stratas have no leadership and the agency found great potential for improvement and change.

**Organisation and Methodology :**

The project-in-charge is a trained social worker who took initiative to establish this project. He belongs to the same area. The project team consists of 9 persons which include community organisers, a woman organiser and a social worker (project-in-charge).

This is a new project and so its actual methodology is still evolving. However, on the basis of social work training of the project-in-charge and other experiences, the agency has outlined its methodology in general terms. The agency works towards developing local leadership in the project villages by implementing various programmes using the participatory model. Many of the programmes undertaken by the agency are in collaboration with government agencies or other voluntary organisations. Thus, it also helps people to utilise government programmes.

**Activities and Achievements :**

In two years of its existence, the agency has carried out several activities :

1. In October 1983, a multi-diagnostic camp was organised in one of the villages. About 500 patients utilised it. In village Kanjara, the agency runs a community health service centre which is being used by about 1,500 patients so far. This centre also undertakes immunisation campaigns. This centre has no doctor but some doctors from Nanded and Parbhani regularly visit it. In January 1984, at this centre, an eye camp was organised and it was utilised by about 100 patients.
2. In January 1984, the agency organised a family planning camp. In this camp, 25 tubectomies and 5 vasectomies were done while 50 copper T were inserted.
3. The agency helped 15 landless scheduled caste families to obtain loan under the IRDP.
4. Due to the agency's intervention, 4 villages have been granted school buildings under the NREP and 5 balwadis were started by the agency in the villages.

In addition to the community health services centre, there are 3 other on-going programmes of the project. They are :

1. Mahila Mandals; (2) Youth Committees; and
3. Mahila & Youth Bhajan Mandals or Kalapathaks (cultural groups)

**Finances :**

Initial financial support to the agency came from Terre des Hommes, Pune, which paid Rs.6,200/-. Other information was not available.

## 22.* MANAVLOK - AMBAJOGAI

**Name and Address of Project** : Manavlok 'Dhadpad'
Sane Guruji Vasahat,
Ambajogai 431 517
Dist: Beed

**Project-in-Charge** : Dr. D.S. Lohiya

The project started with a hospital, associated with the Maharashtra Arogya Mandal in 1974. The Sane Guruji Hospital was run like an other charitable hospital providing medical care at a reasonable cost. However, differences in approach between the project-in-charge and the Mandal surfaced and the former decided to go his own way. Thus in 1982, with the assistance of OXFAM, a community health programme was started as an extension of the hospital. Also, various rural development activities have been undertaken. The project is associated with the Rashtra Seva Dal that is also politically active in the area.

**Aims and Objectives :**

The primary objective of the project is rural reconstruction through intervention that is decided by the people. The operational philosophy as defined by the project is : go to the people, live among them, love them, start with what they know and build on what they have. Since the project-holder

is a medical doctor the starting point for intervention has been health care services; also health was identified as an important felt need by the people because facilities in the area are poor (even though there is a medical college in Ambajogai) and more so inaccessible because of the hilly terrain. Their health programmes are mainly directed towards MCH services.

**Social Geography :**

The project is located in Ambajogai taluka of Beed district. This area is largely a hilly terrain and is very backward. The project presently covers 45 villages, having a population of 75,000 with various programmes.

Ambajogai taluka has a population of 3,33,558 spread over 59,385 household. The average household size is 5.6 persons and the sex ratio is 948 females per 1000 males. The literacy rate in the taluka is 34% (20% for females). Scheduled castes constitute 12% of the population. The non-working population is 58.4% and out of the workers 36.5% constitute agricultural labourers. Half of the villages covered by the project have resources to take on a second (winter) crop. Malnutrition, diarrhoea and goitre are fairly common in the area.

**Organisation and Methodology :**

The project is managed by an executive committee of which the project holder is the secretary. At the apex of its health programme is a hospital with fairly sophisticated facilities and specialist care. In addition to this there are three rural dispensaries (one outside a sugar factory) two working daily and one weekly.

At the village level there is a trained dai. The dai is supported by a mobile team attended by a nurse.

There are four full-time workers for agricultural programmes, three social workers and twenty part-time volunteers who assist in rural reconstruction, health and women's development programmes as well as engaged in politicisation work. Village meetings are conducted regularly where beneficiaries suggest programmes and discuss various issues. These help the project staff in planning and implementing of programmes.

**Activities and Achievements :**

In its community health programme the project provides services through trained dais. The dais conduct deliveries, carry out awareness campaigns about diseases and hygiene and promote ante-natal care, immunisation and family planning. They do not dispense any medicines - they only identify cases for treatment by the mobile dispensary that covers each village once in fifteen days. The services rendered by the dais and the mobile dispensary are free of cost. However, cases referred to the hospital or any dispensary is charged on a no-profit basis.

In addition to the health programme the project runs a day care centre for children of women workers, a centre for training in sheep breeding and wool weaving, a home for destitute children, various experimental/demonstration agricultural programmes to improve productivity and marketing, a shelter home, home industry training and free legal aid centre for women. The project has also started recently a 'Krishak Panchayat' an organisation for marginal farmers that extends interest free seeds and fertilizer

loans. A drought area development programme has alsobeen undertaken to construct small bunds, community lift irrigation, digging of wells, etc., for small farmers.

No data pertaining to changes after project intervention was made available.

**Finances :**

The project is funded by OXFAM, Terres des Hommes and AFARM; it also receives individual donations and contributions. Besides, collection from health care services also contributesto the project's income.

Details about expenditure were not made available.

## 23.* VIVEKANANDA HOSPITAL, LATUR

**Name and Address of Project** : Vivekananda Medical Foundation & Research Centre, Vivekanand Hospital, Vidyanagar, Latur 413 512

**Project-in-Charge** : Dr. R.K. Alurkar

The Vivekananda Hospital was started as a private group practice in 1966 and was converted into a public trust in 1979. It was only then that the extension health services programme was also incorporated; but their rural health programme is very unlike other community health programmes - it is a doctor based programme. The hospital itself is a highly sophisticated institution having a 100 bed capacity; it has fourteen specialist doctors, including facilities for cardiac cases and dialysis. The hospital is also an approved institution for medical research with grants from the ICMR. The founder doctors have been associated with the RSS. They attribute their service attitudes and orientation to the preachings of the RSS ideology.

**Aims and Objectives :**

The trust was set up after a team of dedicated doctors got together to work for social betterment through medical care and for promoting their religio-ideological tenets through social services. The memoranda of the trust outlines the following objectives :

1. To evolve and conduct medical institutions of various types like nursing homes, rehabilitation homes, dispensaries, orphanages and clinics for the service of humanity.
2. To create a sense of dedication, devotion and selfless services in the medical profession, specially in the young generation.
3. To evolve a team of paramedical workers to work in the specified medical institutions, to teach and train them in the art of nursing and serving the patients.
4. To undertake research and education in the field of medicine.
5. To undertake any medico-social activities, specially in backward areas of the country in co-ordination with hospital services.
6. To undertake any activity as would be useful for serving the victims of natural and social calamities.

7. To make medical aid available at a reasonable cost for all strata of society.

8. To procure services of doctors, surgeons, medical practitioners, including vaidyas, hakims, homoeopaths, nurses, assistants, attendants and servants either on remuneration, gratuity or in any honorary capacity.

**Social Geography :**

The project's activities are located in Latur district (bifurcated recently from Osmanabad district). Latur town is an important trading centre in southern Marathwada but otherwise it is a backward region highly stratified with large chunks of Muslim and dalit population.

The outreach programme of the hospital is currently located in three talukas (Latur, Ausa and Ahmadpur) which together constitute a population of 7,04,424 spread over 1,20,872 households. The average household size is 5.8 persons, the sex ratio 951 females per 1000 males and the literacy rate 36% (22% female). The scheduled castes constitute 15% of the population and Muslims more than 20%. Agricultural labourers constitute 36% of the workforce and non-workers 56% of the population.

The main causes of morbidity and mortality identified by the project are infectious diseases such as dysentry, typhoid and jaundice; poor ante-natal care; poverty and illiteracy and delays caused by poor transport facilities.

The project has already done groundwork to establish another seven rural subcentres, which would mean a coverage of almost the entire district.

**Organisation and Methodology :**

Vivekahanda Hospital is like any other hospital having facilities for modern sophisticated medical care, including super specialities. But its outreach program is distinctly different from that of other voluntary agencies running rural health programmes. This project insists that medical care provided to the impoverished rural population must be of the best quality. Therefore they have evolved a strategy of rural health programmes which are entirely doctor based. Their modus operandi is setting up a network of rural dispensaries or hospitals run by a doctor for every 10 kms radius population. So far they are operating three such centres, two with resident BAMS doctors and one with a weekly clinic run by a hospital specialist doctor. They are presently trying to establish seven more rural sub-centres but their main problem is to get doctors to reside in the sub-centre village.

Providing cheap and easily accessible medical care is not the only objective of this outreach program. Through medical care it is intended to provide socio-religious education using the media of "shakhas", "prathanas" and "shibirs". It intends to make each of the subcentres as self-sufficient as possible and the entire surplus of the subcentre is to be used for the village's social and economic development programmes.

**Activities and Achievements :**

Besides sophisticated hospital services and doctor manned rural health subcentres the project has an ambulance service, a regular slum clinic, holding of opthalmic, surgical and diagnostic camps, health education for school children and lay public, regular immunisation services in village health centres and social education. The project is mainly curative and fee-for-service oriented. The hospital also undertakes medical research, including clinical studies and drug trials.

**Finances :**

Initially the hospital expanded on the basis of voluntary donation but now it obtains most of its income from hospital services.

According to the project's income/expenditure statement for the year 1984, its total income was Rs.1.92 millions, hospital collections accounting for 77% and bank loans 20% of the income. The expenditure was Rs.1.57 million out of which salaries accounted for 46%, medicines 14% and transport and fuel 8.5%. Expenditure on outreach programmes was not available separately; it is included in the above stated expenditure.

## PUNE REGION


This region is constituted by the southern districts of Kolhapur, Sangli, Solapur, Satara, Pune and Ahmednagar. On the whole it is a relatively developed area well known for its "sugar-politics". This region is the heart of the sugar cooperative movement and thus dominated by sugar barons who are backed by a strong and significant class of the "middle" peasantry. These southern districts largely dominate the politics of the state.

## SOCIAL, ECONOMIC AND HEALTH INFORMATION : PUNE REGION DISTRICTS

| Districts | Population (Persons) 1981 | Urban Popuin. (Percent) 1981 | % Area of State 1981 | Density per km. (Persons) 1981 | Average Household Size (Persons) 1981 | Popuin. Growth 1971-81 (Percent) | Literates (Percent) 1981 | Female Literacy (Percent) 1981 | Sex Ratio (F/1000M) 1981 | SC Popuin. (Percent) 1981 | ST Popuin. (Percent) 1981 | SC as % of State 1981 | ST as % of State 1981 | No. of Villages |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ahmednagar | 2708309 | 13 | 5.5 | 159 | 5.67 | 19.36 | 43.16 | 29.24 | 959 | 10.62 | 6.93 | 6.42 | 3.25 | 1503 |
| Pune | 4164470 | 47 | 5.1 | 266 | 5.43 | 31.04 | 54.03 | 42.14 | 937 | 7.54 | 3.81 | 7.00 | 2.75 | 1753 |
| Satara | 2038677 | 13 | 3.4 | 194 | 5.33 | 18.02 | 48.15 | 35.67 | 1061 | 6.21 | 0.64 | 2.83 | 0.23 | 1417 |
| Sangli | 1831212 | 21 | 2.8 | 214 | 5.54 | 18.92 | 46.87 | 33.60 | 967 | 11.16 | 0.85 | 4.56 | 0.27 | 708 |
| Solapur | 2610144 | 29 | 4.9 | 174 | 5.64 | 15.81 | 40.68 | 26.96 | 942 | 14.29 | 1.98 | 8.33 | 0.89 | 1104 |
| Kolhapur | 2506330 | 25 | 2.6 | 311 | 5.60 | 22.38 | 45.36 | 30.79 | 967 | 12.08 | 1.09 | 6.76 | 0.47 | 1200 |

| Districts | CMIE Index Score 1980 | Main Workers (Percent) 1981 | Non-Workers (Percent) 1981 | Agricultural Labourers as % of main workers 1981 | Sex Ratio of Agric. Labourers F/1000 M 1981 | Ratio of Agric. Labourers to Cultivators (Percent) 1981 | % Main workers in Non-Agricultural sector 1981 | Average Size of Operational holding (hectares) 1976-77 | Per Capita Production of Food Grains (Kgs) Avg. of 1975-1980 | Avg. Daily Employment in Factories (Per 1,00,000 population) 1977 | Per Capita Bank Deposits (Rs.) 1983 | Per Capita Bank Advances (Rs.) 1983 | % Forests Area (Percent) 1973-74 | % Villages Electrified (Percent) 1984 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Ahmednagar | 132 | 41.6 | 54.3 | 28.33 | 1062.0 | 59.73 | 24 | 4.0 | 184 | 733 | 369 | 363 | 11 | 99 |
| Pune | 211 | 34.9 | 61.5 | 13.61 | 1161.3 | 39.93 | 52 | 3.6 | 116 | 3074 | 2027 | 1383 | 12 | 87 |
| Satara | 93 | 33.6 | 58.6 | 18.39 | 1151.6 | 34.78 | 29 | 2.4 | 146 | 537 | 495 | 316 | 14 | 95 |
| Sangli | 93 | 34.1 | 61.0 | 22.37 | 747.8 | 46.74 | 30 | 3.0 | 157 | 663 | 573 | 346 | 5 | 96 |
| Solapur | 93 | 37.7 | 58.4 | 29.54 | 951.4 | 85.71 | 36 | 5.4 | 164 | 1138 | 510 | 345 | 2 | 99 |
| Kolhapur | 106 | 36.8 | 58.6 | 14.96 | 814.3 | 28.43 | 32 | 1.8 | 118 | 1177 | 536 | 435 | 19 | 91 |

| Districts | Voluntary Hospitals 1979 | Govt. Local Body Hosp. 1979 | P H C S 1983 | P H C S 1984 | Rural Hosp. 1984 | B C G Vaccination 1983-84 | DPT Vac. 1983-84 | Polio Vac. 1983-84 | T.T. Mothers 1983-84 | T.T. Upto 16 years 1983-84 | Tubectomy 1983-84 | Vasectomy 1983-84 | IUDs 1983-1984 | Estimated Eligible Couples 1983-84 | Couples Currently protected by 1983-84 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | Sterilisation | IUCD | Other Method |
| Ahmednagar | 31 | 10 | 21 | 84 | 5 | 135400 | 139893 | 85559 | 84468 | 54520 | 21164 | 7605 | 30857 | 497000 | 206550 | 24810 | 13385 |
| Pune | 30 | 32 | 26 | 78 | 8 | 128541 | 126711 | 114132 | 82545 | 74108 | 41544 | 11526 | 48026 | 772000 | 349056 | 45642 | 19985 |
| Satara | 34 | 9 | 19 | 63 | 6 | 135497 | 92264 | 64613 | 59549 | 55355 | 16911 | 6241 | 29680 | 388000 | 153651 | 26360 | 16048 |
| Sangli | 32 | 5 | 13 | 52 | 5 | 139498 | 96468 | 70306 | 61839 | 48777 | 14490 | 3186 | 22866 | 333000 | 150943 | 19022 | 9575 |
| Solapur | 55 | 12 | 18 | 58 | 4 | 137497 | 105231 | 43245 | 65687 | 74401 | 25575 | 6809 | 27742 | 460000 | 222788 | 23841 | 11643 |
| Kolhapur | 24 | 14 | 16 | 64 | 5 | 152000 | 105284 | 83353 | 59648 | 78719 | 23016 | 5542 | 27465 | 444000 | 200221 | 22462 | 14372 |

Sources : Compiled from :


1. Census of India: 1981, Series - 12, Maharashtra, Primary Census Abstract Part II-B, Govt. of Maharashtra, Bombay, 1983.
2. Profiles of Districts, Part I : A-K, Part II : L-Z, Centre for Monitoring Indian Economy, Bombay, 1985.
3. Performance Budget, 1985-86 - (a) Family Welfare, (b) Medical (Non-teaching Hospitals), (c) Public Health and Sanitation, Government of Maharashtra, Aurangabad, 1985.

## 24. AVATAR MEHER BABA PERPETUAL CHARITABLE TRUST, AHMEDNAGAR

**Name and Address of Project** : Avatar Meher Baba Perpetual Public Charitable Trust,
Post: Meherabad,
Dist: Ahmednagar

**Project-in-Charge** : Ms. Manija Sheriar Irani

This project, located at Meherabad (Arangaon) in Ahmednagar taluka was started in 1973 as a small dispensary and it is today a 25 bed hospital.

It is a charitable institution run aboslutely free under the auspicies of the Trust. It has no community health services or outreach programme. It provides curative care free of cost to any one visiting the dispensary. The project indicates that its catchment area is a population of about 70 villages.

**Aims and Objectives :**

The project was started by the Trust under the instructions given by Avatar Meher Baba in the Trust Deed. The objective is to provide selfless social services to the deprived and under-privileged population in the rural areas in and around Arangaon; medical relief, veterinary care, agricultural programmes and educational activities are some of the areas through which the project seeks to realise its objectives.

**Social Geography :**

The project dispensary is situated in a developed area where sugarcane farming due to adequate irrigation facilities has transformed the area in the last one and a half decades. However, the project dispensary is located in a village that has a water problem. Half the population of Ahmednagar taluka is urban and the literacy rate is 57% (43% female). The average household size is 5.74 persons and the sex ratio is 893 females per 1000 males. The non-working population constitutes 60.4% of the population and among the working population 13% are agricultural labourers (54.7% being women), and 32% cultivators. According to the project reports malnutrition, diarrhoeal and parasitic diseases, rheumatic pains, skin diseases and respiratory tract infections are the major morbidity factors in the area.

**Organisation and Methodology :**

The project provides social services purely as a mission for charity. It's dispensary is staffed by 2 doctors, a nurse and paramedics; there are also volunteer doctors and nurses associated with the dispensary. Homoeopathic, ayurvedic, herbal, chiropractic and acupuncture services, besides allopathic are also provided. Laboratory services are also available.

**Activities and Achievements :**

As part of their medical relief programme mainly curative services are provided at the centre. There are no outreach programmes except for occasional camps organised at the centre itself. The average attendance at the dispensary in 1981-82 was 53 patients per day, half of which on an average are new patients; in 1982-83 the average attendance was 64 patients per day and in 1984 the average attendance was 86 patients per day.

**Finances :**

The Trust is funded through donations from followers of Avatar Meher Baba in India and in other countries.

In the year 1984 the Trust spent Rs.13.85 lakhs. Out of this capital expenditure constituted Rs.6 lakhs (43%) and Rs.7.85 lakhs was revenue expenditure (57%). Within capital expenditure medical facilities constituted 27% and educational facilities 62% of the expenditure. Under revenue expenditure medical relief was 20% of the expenditure, education 15%, administration 23% and religious activities 15%. On the whole expenditure on medical programmes was 23% and on education programmes 35.5%.

## 25.* CENTRE FOR CO-OPERATIVE RESEARCH IN SOCIAL SCIENCES

**Name and Address of Project** : Centre for Co-operative Research in Social Sciences
Rairkar Bunglow,
884, Deccan Gymkhana,
Pune 411 004

**Project-in-Charge** : Dr. Guy Poitevin

This project is aimed at the study of the process of conscientisation by providing socially relevant health education to the people. Its activities are integral to the activities of the Garib Dongar Sangathana, a peoples' organisation in the area. In fact all field activists of the project are also activists of the Sanghathana. The dynamics of the project are not separated from the dynamics of people's struggles and self-organisation but is an integral part and endeavours to be a catalyst in the process. The project was started in 1980.

**Aims and Objectives :**

The aims and objectives of the project are not available. However, the agency outlined aims of a proposed study of the project as the study of reciprocal determination of three series of processes among marginalised rural population.

1. Spreading of medical knowledge and liking for technical medical education and consequent improvement of health status among rural poor.
2. Processes of socio-cultural and socio-political awakening, especially with reference to the present contradictions and dysfunctions of the health care system, and consequent people's organisation to deal with health problems as well as other issues.
3. Autonomous efforts to promote attitudes and concrete attempts of collective self-help in respect of primary health education and health care especially among the weaker sections.

**Social Geography :**

The project area is located in remote and hilly areas of Velhe and Mulshi talukas of Pune district. Both the talukas are underdeveloped with no urban areas. Only 28% and 37% of the population are literate in Velhe and Mulshi talukas respectively. The working population constitutes only 35% and 38% respectively and amongst them most are cultivators.

The project covers hilly areas of these talukas wherein reside tribal and semitribal people who are mostly marginalised cultivators. It covers a population of about ten thousand people.

**Organisation and Methodology :**

The agency does not run any health centre as such. In fact, the agency's intervention is to conscientise the activists and masses of rural marginalised people who are part of an organisation called Garib Dongar Sanghathana. Health is only one dimension of the entire process of conscientisation.

The chief agents of the agency selected from the activists of the Sanghathana are health animators. They are community health workers but different from what is conventionally meant by CHWs. They are trained to cure some minor but more prevalent diseases in the area. This curative work gives them confidence and at the same time helps them in their activities of organisation. This curative knowledge thus is not imparted merely as bio-technical knowledge. The social and radical critique of health services is also explained in much more concrete terms based on their daily experiences. Since the agency does not by itself provide health services, these animators who have become conscious of health needs of the people from the training process and from their daily health work, seek further health reliefs from the government health centres. This is reflected in the demands related to health raised by the Sanghathana.

Thus, this methodology neither neglects the immediate relief of common diseases affecting people nor goes to the other extreme of absolving the government agencies of their responsibility in providing health care by becoming a voluntary or private agency catering to most of the health needs of the people. This methodology unleashes processes of conscientisation not only in the field of health but in all fields - social, economic and cultural.

The health animators are given continuous training by a socially conscious doctor. Apart from them a community organiser visits villages, interact with villagers, helps in the activities of Sanghathana and provides a link with the agency.

**Activities and Achievements :**

The inputs provided by the project and it's staff are very limited. So strictly speaking, the agency's activities cannot be described as more than training and interacting with the health animators and the work of the community organiser. However, the agency supplies medicine at cost price to the health animators who recover money from the beneficiaries. Apart from that initially the agency paid all health animators an honorarium of Rs.50/- per month, which was later stopped. At present an honorarium is given to only those health animators who visit other villages, as community organisers "with health in hand"as they are called. They are given Rs.5/- per day spent on organisational activity besides the expenses incurred to attend training and camps.

Thus, the actual activities and achievements of the project are relfected in the activities of the Garib Dongar Sanghathana about which we do not have information.

**Finances :**

The chief source of funds is Terre des Hommes (Germany). The health project is part of an educational project called "school without walls" which includes women's meetings and education, evening schools, balwadis, youth camps and schools. For the entire project, the agency spent about Rs.49,000 in 1984; the health component accounted for roughly one third of the amount.

## 26. CENTRE FOR STUDIES IN RURAL DEVELOPMENT

**Name and Address of Project** : Centre for Studies in Rural Development
Ahmednagar College,
Ahmednagar.

**Project-in-Charge** : Miss Usha Lolge

The Centre for Studies in Rural Development (CSRD) has been involved in the field of rural, tribal and urban development for the last 22 years. The CSRD operates various developmental schemes in about 80 villages in Ahmednagar and Beed districts of Maharashtra. The CSRD is an educational institute which offers a post-graduate course in social work, affiliated to the University of Pune.

**Aims and Objectives :**

Before starting programmes in the field of health, the CSRD conducted a survey on "Attitude of Rural Women Towards Health & Family Planning". On the basis of the findings of the survey the agency made community health education the chief aim of its activities, at least in the first year of its operation. In the course of further development of the project, the agency formulated its objective as following :

1. To educate the village community, especially mothers and young girls, in the area of health, sanitation, balanced diet (nutritional needs) and good habits of physical cleanliness, family planning methods, economic activities, etc. in simple language and by proper demonstration.
2. To provide medical facilities to the village community.
3. To eradicate superstitious beliefs of the rural community, their traditional way of treating people and harmful customs.
4. To give opportunity to students of social work to study the health problems of rural community and to involve them in finding solutions to solve these problems.

**Social Geography :**

Presently the health project covers 10 villages near Ahmednagar city, 8 of them are in Ahmednagar taluka and 2 in Ashti taluka. The villages are dispersed and the area is hilly.

In a survey carried out by the centre it was found that the major problems of the people were poor diet, primitive sanitary conditions, lack of safe drinking water, unhealthy habits, lack of proper medical care - both curative and preventive, lack of health education, lack of proper housing, population explosion and reluctance to make use of available health services. Women and children suffered the most due to these problems.

The dominant caste in the project area is Maratha, comprising 90% of the population. The data supplied by the agency give other indicators as follows : Only 10% of the population is literate. 10% of the workers are landless agricultural workers, while 25% are small and marginal cultivators. The current birth rate in the project area is 16 per 1000 and death rate 6 per 1000. All the villages get perennial potable water supply and electricity has reached 7 villages. Public transport is available in all these villages. In these 10 villages, no doctor has set up private medical practice.

The main crops grown in these villages are jowar, wheat, bajra and groundnut. The main causes of morbidity as reported by the agency are malaria and water borne diseases like cholera and jaundice.

**Organisation and Methodology :**

The main method used to bring about changes in the community is health education. Various activities like organising women's groups, community meetings, balwadis and pre-primary school, provide information and education to change people's perception and practices for better health. At the same time these activities also help in the social and economic upliftment of the project population. They also provide curative medical services to meet health needs of the people.

This methodology is also reflected in the evolution of the centre's organisational structure. The agency started with one lady extension officer and a social worker. With the expansion of activities, a doctor, a project officer and others were added in the staff. The director and project-in-charge head the project. The agency also trained village level health workers selected by the community. These workers were trained in a seven day training programme and then on a continuous basis every month. The training was given by a doctor, nurse, public health nurse and social worker according to the needs.

Presently there are 10 village level health workers for 10 villages. Each is paid by the agency in the range of Rs.50/- to Rs.90/- per month. They charge for the services extended to recover cost of the medicine.

These workers are supported by a mobile team (with a doctor) which visits each village once in a week. Seriously ill patients are helped by the agency to get admission in the city hospital.

**Activities and Achievements :**

The project started in one village with a population of 1445 in 1977. This village was selected because in 1972 when the CSRD organised a farmers' rally, the people of this village had come in contact and invited the CSRD to adopt their village. The first programme started by the agency was to organise a women's group and start a pre-primary school. Later on health and socio-economic programmes were started.

1. **Health :** The activities in this field include giving health education to people, particularly women and children, providing simple curative care through village level health workers, immunisation, medical check-up of balwadi children, maternal care and so on. Family planning is also given emphasis.
2. **Education :** The agency conducts a pre-primary school and adult literacy classes.
3. **Socio-Economic :** Economic programmes include poultry, sheep and goat rearing, encouraging small savings and dairy farming, etc. The agency also organises women's tours to remand and leprosy homes, home for the aged, girls' boardings, agricultural university, banks, sugar factories, civil hospital, and such other places.

For providing health education, the agency uses various types of audio-visual aids and demonstration.

**Finances :**

Sources of funds include state government, central government and various donor agencies.

The centre spends slightly more than one lakh rupees per year for its various activities. Out of this, 39% are spent to pay staff salaries, 12% for health programmes, 22% for non-health activities and 27% are spent on transport and overheads.

## 27.* COMPREHENSIVE RURAL HEALTH PROJECT, JAMKHED

**Name and Address of Project** : Comprehensive Rural Health Project, (CRHP), Jamkhed.

**Project-in-Charge** : Dr. Rajnikant Arole.

This project which is affiliated to the Marathi Church Mission was started in 1970 by Rajnikant and Mabelle Arole, both doctors with a publich health degree from John's Hopkins. The Aroles with their earlier exposure to rural health care realised that 70% of the diseases were preventable, but perpetuated because the basic approach was wrong. After their training in community medicine they drew up detailed plans based on the following criteria :

1. Local communities should be motivated and involved in decision-making and must participate in the health programme so that they ultimately "own" the programme in their respective communities and villages.
2. The programme should be planned at the grass roots and referral system developed to suit the local conditions.
3. Local resources such as buildings, manpower and agriculture should be used to solve local health problems.
4. The community needs total health care and not fragmented care; promotional, preventive and curative care need to be completely integrated, without undue emphasis on one particular aspect.

Armed with this philosophy Jamkhed was identified as suitable because it was a neglected area with no organised health service and also because it was an area lacking a strong power base.

To begin with, an area with 40,000 population in 30 villages around Jamkhed was selecgted and the following socio-medical problems were identified :

1. Rapid increase in population;
2. High infant mortality and continued high mortality in the first five years of life;
3. Prevalence of chronic diseases such as tuberculosis and leprosy;
4. Lack of facilities for adequate health care; and
5. Inadequacy of food and water.

Today the project has considerably expanded, covering almost all villages of Jamkhed and Karjat talukas serving a population of 2,41,922.

**Aims and Objectives :**

Given the above identified conditions and the backwardness of the area following objectives were set out :

1. To reduce the birth rate from 40 per 1000 to 30 in six years (1971-1977);
2. To reduce the mortality rate of under-fives by 50%;
3. To identify and bring under regular treatment patients with tuberculosis and leprosy;
4. To provide basic primary health care;
5. To offer field training to nurses, interns and other health professionals;
6. To create sources of potable water supply; and
7. To provide supplementary nutrition to pre-school children.

At a later stage programmes for economic development (irrigation, alternate energy, dairy and poultry farming, education, small scale industries, etc.) have increasingly acquired a focus and development of health is seen as a part of general economic development of the community.

**Social Geography :**

Jamkhed and Karjat talukas constitute a dry rocky terrain that is drought prone. Economically these two talukas are the most backward in Ahmednagar district, which in recent years has seen a great amount of development through sugarcane production.

Jamkhed and Karjat are both entirely rural talukas, the scheduled castes constituting 13.5% of the population. There are a total 43,090 households in the two talukas and the average household size is 5.6 persons. The sex ratio is 964 females per 1000 males and the literacy rate is 36.8% (22.8% female), much below the state's literacy rate of 47%. The work force comprises of mainly cultivators (60%) and agricultural labourers 25% (51.5% female) and the non-workers constitute 51% of the population.

**Organisation and Methodology :**

The year the project was started was one of severe drought. Thus the priority was food and water. Aid, mainly from international church agencies was organised to provide food supplies since local resources were inadequate; community kitchens were organised in a few of the selected villages and the community was entrusted with the responsibility of organising fuel and vessels, as also to cook the food. Water sources were created by digging bore-wells in the villages and capital was employed in improving agriculture productivity. These interventions and the popularity and reputation gained in clinical services at the clinic at Jamkhed became the springboard for launching the community health programme.

Initially hospital staff and social workers were recruited to start the health centre at Jamkhed and as contracts were established with the periphery, mobile teams began providing services in the villages itself.

At the apex of the project is the governing body composed of the chairman, secretary, treasurer and members. The constitution provides that the governing body should represent various national voluntary organisations, one or two representing the nursing profession. The function of the governing body

is to review and approve the annual budget, appoint a project director and approve the general policies of the project. The governing body has given the director full authority to appoint staff, fix salaries and adopt rules and regulations for the functioning of the project.

In addition to the hospital and administrative staff, over the years a network of health workers who stay in the village has been developed - they provide primary health care to the population. The CHWs after an initial training of one week receive continuous in-service training at the health centre for two consecutive days every week; once aweek her village is visited by a mobile team consisting of a nurse or ANM and a paramedic worker, sometimes accompanied by a doctor and a social worker.

The health centre at Jamkhed is a 40 bed hospital. It is the referral centre in addition to being the administrative and training headquarters of the project. Currently at CRHP CHWs are trained for the entire Ahmednagar district. Also under construction is a school for public health nurses; the courses is being developed in collaboration with VHAI. Besides the Aroles (both physicians) there is a BAMS doctor, backed by regularly visiting specialists. There are also four subcentres in Karjat taluka under the charge of a nurse to facilitate referring of cases since the distance to Jamkhed is considerable. The hospital is equipped with X-ray machines, laboratory equipment, an operation theatre and a blood bank. The project maintains good relations with the government's health and administrative structure - in fact the entire leprosy programme for the two talukas has been handed over to CRHP with full financial assistance.

To ensure adequate support at the grass roots level the project has initiated the formation of "Young Farmers Club" and Mahila Mandals. Through these groups development activities are undertaken and support is provided to the health problems; also socio-political credibility of the project is established.

**Activities and Achievements :**

This project can truly be classified as a comprehensive project which has developed through the "felt-needs" of the population it serves. It began with curative services and took up the crucial issue of food and water scarcity. Through this the credibility of community health services were established and subsequently development activities have increasingly acquired a focus.

The CHW's routine activities include conducting the nutrition programme, treatment of minor/ common ailments, monitoring child health, follow-up of pregnant and lactating women, promoting family planning and environmental health through health education and maintenance of vital statistics and health data. The CHW is paid on honorarium of Rs.50/- per month from government allocated funds - a few selected and experienced CHWs get an additional amount of Rs.70/- per month from the project. The CHW is supported by the mobile team in which the nurse follows up ante and post-natal cases, conducts immunisation and holds a weekly curative clinic. The paramedical worker follows up leprosy and tuberculosis patients.

Through the "Young Farmers' Club" and Mahila Mandals the project has undertaken activity such as agricultural and water resources development, afforestration, developing alternate energy sources, road and other community asset construction, collectively buying modern agricultural equipments, encouraging growth of kitchen gardens, assisting households in undertaking various economic activities including taking advantages of the government's IRDP and loan dispersal programmes and undertaking nonformal education programmes among other things.

Over a decade (1971-1982) the project has had a considerable impact as suggested by the following data : birth rate has been brought down from 40 per 1000 to 23 per 1000 population, death rate to 8.5 per 1000, IMR from 180 per 1000 live births to 41 per 1000, immunisation coverage (triple and polio) from 0.5% of under-five population to 98%, reduction of malnutrition from 38% of pre-schoolers to 6%, improved case detection and holding for leprosy and tuberculosis patients, ante-natal coverage from 0.5% to 98%, increase of eleigible couples practicing family planning from 1% to 53% and coverage of couples eligible for sterilisation at an astounding 96% (average household size has declined from 6.14 persons in 1971 to 5.6 persons in 1981). The CHW treats 78% of all cases and 94% of under-five cases.

**Finances :**

The project is largely funded by church organisations such as the Christian Medical Commission. The project estimates a per capital expenditure (1982) on health care of Rs.15/-, out of which Rs.5/- is for community health services. 75% of the recurrent expenditure is met by patient fees. The government provides 4% of the budget, foreign donations the remainder. Curative services account for 30% of the budget, preventive services 60% and administration 10%. The village communities have donated land, contributed building, materials and provide free labour for various programmes of CRHP.

## 28. INTEGRATED HEALTH SERVICES PROJECT, MIRAJ

**Name and Address of Project*** : Integrated Health Services Project,
Miraj Medical Centre,
Miraj.

**Project-in-Charge** : Dr. Eric Ram

*This project was terminated in 1977.

The IHSP commenced its activities from July 1973. This project was a collaborative effort of the Miraj Medical Centre and the Sangli Zilla Parishad and it aimed at demonstrating an integrated pattern of health services which could be replicated in other areas also.

The project covered the entire Miraj Taluka (rural) which at commencement had a population of 2,16,335 spread over 58 village and distributed into 37,219 households. The Miraj Medical Centre was handed over complete charge of administering rural health care services in Miraj taluka.

**Aims and Objectives :**

The project aimed at demonstrating that within the context of the existing infrastructural framework and resources the efficacy and performance of health services could be improved considerably. The project set itself the objective of strengthening primary health care services so that health care, MCH and family planning services were available to the population easily and at a minimal cost. This was to be achieved through re-training of health personnel from the Medical Officers to the basic health workers and training of traditional dais and village health assistants. Since the primary objective of the project was to demonstrate a change towards greater efficiency of the health care delivery system, a baseline study was carried out in 1974 to generate data so that a post-intervention comparison was possible.

**Social Geography :**

The general geographical and demographic feature of Miraj taluka based on the 1981 census have been described in the Wanless Hospital Project profile. The base-line survey (1974), based on 10% random sample, revealed that the average rural household size was 5.8 persons and the sex ratio 910 females per 1000 population; the 0-14 years population constituted 39.8% of the entire population; 47.5% of the population was illiterate; 11.39% (of the entire population) were agricultural labourers; crude birth rate was 26.3 and crude death rate 9.8 per 1000 population; infant mortality rate was 67.6 per 1000 live birth; 76.6% of all deliveries were conducted at home, and untrained dais conducted 70-80% of all deliveries. Miraj being a developed area many of the health indices were also much better than the state or National average. It must be noted here that Miraj is also a highly 'medicalised' area with an unusually large number of private hospitals and practitioners.

**Organisation and Methodology :**

Organisationally the project is like any government run health care delivery system. For 2.16 lakh population there were three primary health centres in 1973, each with two doctors and the regular paramedical staff of ANMs and Basic Health Workers (now called MPWs). To this the Miraj Medical Centre which was given temporary administrative control of government health services in Miraj taluka added trained dais (173) and female village health assistants (40).

The strategy adopted to realise stated objectives was retraining and reorientation of the existing health staff so that their outreach to the population becomes more meaningful and effective; infact, the Miraj experiment was a test-case for changing the vertical health workers (vaccinators, malaria surviellance workers, etc.) into multipurpose workers (MPWs).

The training of trainers was conducted by specialists from the Miraj Medical Centre, VHAI, CMAI, as well as from State and Central Governments and was geared towards promoting the concepts of integration of health services. After such orientation was provided to the trainers who were from the PHC, District Health Office, State Health Office and Miraj Medical Centre, the training programme for paramedics was conducted for six weeks. Untrained dais and village health assistants received one week's training, the former for improved and hygienic delivery practices and family planning motivation and the latter in assisting ANMs in MCH, family planning and ANC/PNC follow-up. They received a wage of Rs.60/- per month.

The project employed the services of a demographer whose task was to monitor and continuously evaluate the data that was generated.

**Activities and Achievements :**

Since the project's thrust was mainly reorientation for greater efficacy of the existing health services, there were no changes in the activity component of primary health centres. As a result of better information management after the project's intervention the weaknesses and lucanae were easily identified and this resulted in more efficient management practice. Those responsible for reducing efficiency could easily be identified and therefore performance rates showed an upward trend.

The main activities included immunisation, MCH, family planning, health and nutrition education, school health examination, treatment or minor ailments by paramedics and nutrition programme for under-fives and pregnant and lactating women.

In 1976, an evaluation was conducted for a 10% random sample to identify changes. Some of the findings are given below :

The sex ratio had delcined to 882 from 910 females per 1000 males; the population had grown at the rate of 1.6% per year; the 0-14 year age group population declined by 4% in two years; 43% decline of marriage of females in age group 10-14 years; illiteracy declined by 5%; birth rate fell at the rate of 2.7% per year but death declined even faster at the rate of 4% per annum; infant mortality rate declined by 49.1% in two years to 34.4 per 1000 live births; BCG protection increased by 809% in two years covering 55% of under-five population; DPT protection increased from 2% coverage to 85% coverage of under-fives and polio from 1.5% to 83%; percentage of couple protection against conception increased from 30% of eligible couples to 89% (for Muslims it increased by 78% whereas for Christians and Harijans it declined by 30%); percentage of mothers receiving ANC was 97%; utilisation of PHCs increased by 24% over two years and that of subcentres by 288%, but the PHC doctors' subcentre visits declined from 42% of expected visits to 27% of expected visits over the two years.

The findings reveal that with intensive monitoring by an agency interested in demonstrating the success of a model it is possible to bring effective and productive changes in the health care delivery system. The most significant impact of the project, besides its noteworthy achievement in immunisation and family planning, has been the demonstration of the fact that the conversion of unipurpose (vertical) workers into integrated health workers, making them more acceptable to the villagers for minor ailments, reduces not only the burden of PHCs but also expenditure on private health care (the integrated health workers charged 25 paise for 3 days medicines). On the basis of this experiment the Maharashtra government adopted the MPW Scheme.

**Finances :**

The project was jointly funded by SIDA, CMC of WCC and the Maharashtra government. The per capita annual cost of the project was Rs.3.70; and in addition to this Rs.90,000/- (or Re.0.40 per capita) was recovered from the community as payments for medicine. This was ploughed back to buy more medicines. 88% of the expenditure was on salaries (20% of which was on non-service staff, i.e. specially appointed project staff) and only 8% on medicines and supplies. The Maharashtra government provided 74% of the funds out of which 95% were spent on salaries of govt. employees. Out of the funds from other sources 63% were spent on salaries and 21% on medicines and supplies.

## 29.* LOKMANYA MEDICAL FOUNDATION, PUNE

**Name and Address of Project** : Lokmanya Medical Foundation and Research Centre, Chinchwad, Pune 411 033

**Project-in-Charge** : Dr. V.G. Vaidya

Lokmanya Medical Foundation is running two projects. The urban project is in Chinchwad, an industrial town near Pune city. It is hospital based. This area was selected because the managing trustee of the agency was working in Talegaon, a town on the Bombay-Pune road. He found that Chinchwad was devoid of good hospital facilities. The hospital was established in 1972-73.

The second project covers surrounding villages. The workers receiving treatment from the hospital made the agency realise that in their villages there were no medical facilities. Therefore, the agency started its rural project known as the Jambe project in 1977.

**Aims and Objectives :**

No specific objectives for the urban project are available. However, for the rural project the agency has defined its objectives as follows :

1. To bring medical care to all people regardless of their ability to pay;
2. To make rural areas the nucleus of the health system which is part of total development;
3. To emphasise the preventive approach through health education programmes and communication; and
4. To actively involve the community in all development programmes in the absence of which health services will not provide lasting results.

The philosophy behind these objectives and the activities are outlined by the agency as :

1. Good health depends less on medicines than on adaption to the environment;
2. Most common diseases are self-curing;
3. Traditional home remedies can cure almost all these minor ailments, rarely requiring allopathic treatment;
4. Proper health education will make us aware of our real health needs;
5. Conventional patterns of curative, hospital based high technology medical care does not offer adequate solutions. More emphasis should be placed on the promotion of health through integrated action programmes.

**Social Geography :**

The urban project area of the agency is highly industrialised and has a population exceeding two lakh persons, with a literacy rate of 60%. About 95% of the working population are employed in the industry. Naturally, the agency's hospital receives numerous cases of industrial injuries and occupational diseases. The research centre of the hospital carry out systematic research in occupational health.

The rural project is in an area near Chinchwad town. It covers 15 villages of the Mulshi taluka. The agency's main centre is at Jambe village 10 kms from Chinchwad. Geographically these 15 villages, having a population of 30,000, form a cluster encircled from three sides by river Pavana and on the southern side they are cut off from village Paud (where the government Primary Health Centre is located) by hills. During the monsoon most of these villages are inaccessible.

**Organisational and Methodology :**

The organistional structure of the urban project is like any other hospital. Apart from Dr. V.G. Vaidya, who is the chief medical officer and managing trustee, there are eight other medical officers - specialists in different fields of medicine.

Jambe, the main centre of its rural project, does not possess infrastructure facilities. Till recently, they did not have any staff permanently stationed in Jambe. In March 1983, the Pune Zilla Parishad posted an ANM. Previously, doctors from Lokmanya Hospital used to visit this area once a week or more often, if required. From January 1983 a doctor has been visiting Jambe every day for three hours.

The project does not have any community health worker. The Gram Panchayat of Jambe has allotted a piece of land to build a dispensary.

**Activities and Achievements :**

The activities of the Chinchwad hospital consist of :

1. A diagnostic centre for 20,000 families of industrial workers;
2. 60 beds - 15 beds for family welfare centre;
3. casualty centre, treating about 800 accidents and injuries per month;
4. Family planning centre. It achieved 238% of the target in 1981-82;
5. Preparation of educational material e.g.: slide shows and exhibition on industrial accidents;
6. It is also an occupational health research centre recognised by the ICMR.

The activities of the rural project are :

1. A village welfare centre at Jambe provides curative medical care and health education to the people;
2. Immunisation;
3. Medical check-up for school children in the area;
4. Organisation of a paediatric camp with the help of the Zilla Parishad;
5. With the assistance of the Rotary Club the agency conducts a nutritional supplement programme for children at Jambe and Nere villages;
6. As part of its educational activities, the agency organised a five-day camp at Jambe. Lectures on agriculture co-operatives, health and family welfare, water supply and bio-gas projects were arranged in this camp.

The agency closely collaborates with government agencies for its programmes. It has also applied to the government for establishing a PHC in this area. But so far the government has deferred its decision in this regard.

**Finances :**

No information was made available about sources of funds and expenditure.

## 30.* MAHARASHTRA AROGYA MANDAL

**Name and Address of Project** : Maharashtra Arogya Mandal,
Hadapsar, (Haveli Taluka),
Pune 28.

**Project-in-Charge** : Dr. S.T. Gujar

Maharashtra Arogya Mandal (MAM) is a public trust started in June 1960 with the establishment of the Sane Guruji Hospital at Hadapsar. The seeds of this project were sown as early as 1960 by the coming together of five socially committed doctors. Among them there was a surgeon, an ENT specialist

and an opthalmologist. One of them, Dr. Baba Adhav, had a dispensary in Hadapsar and so the beginning was made there. But two of them left before 1963 because of financial difficulties. Dr. Adhav left in 1965 for political reasons, in fact he completely left his medical career and went into trade union activities.

**Aims and Objectives :**

In 1960 the intention of the five doctors who came together was to satisfy rural health needs. The aims as stated in the constitution of the MAM are as follows :

1. To provide medical, public health and family welfare services to the rural population;
2. To impart education in different systems of medicines, public health, organise courses and hold examinations and issue certificates and diplomas. To impart health education to the people;
3. To undertake research concerned with health and rural development;
4. To establish dispensaries, schools, libraries, vocational institutions and other bodies to impart education;
5. To work for agricultural and economic development and for the social and cultural uplift of the people. To undertake rural development; and
6. To promote child welfare by establishing homes for orphaned and destitute children.

Of these objectives the ones pertaining to rural development, providing medical and child welfare services are functional.

**Social Geography :**

Hadapsar is now an extended suburb of Pune city; but when the project was started it was a small village with no bus service to and from Pune. The land in the area is of poor to medium quality, interspersed with hillocks which are bare and devoid of any vegetation. The annual rainfall is about 350 mm; most of it falls in the kharif season. The villages are in the upland region and do not enjoy surface irrigation facility. Wells dug with the co-operation of the MAM are the only source of irrigation. Non-food crops and horticulture are the main products of irrigated farming.

The area is very vulnerable to drought. The village economy is largely dependent on the urban market in Pune. A large proportion of the workforce is employed in the manufacturing industry or in construction activity. Among the workers, more than half are cultivators and the proportion of agricultural labourers are substantially low as compared to that of the district or taluka level.

The rural area of Haveli Tehsil in which the project villages fall has a literacy rate of 51% and a sex ratio of 910 females per 1000 males; the average household size is 5.27 persons and non-workers constitute 58.6% of the population.

There are government CHWs in the villages. The PHC is at Khadakvasla and a sub-centre is located in Hadapsar. Today, Hadapsar has 50-60 general practitioners and 6 private hospitals.

**Organisation and Methodology :**

The entry-point was medical work through establishment of the Sane Guruji Hospital in June 1960. The outreach programme was begun with an immunisation campaign in 1967. This was also found inadequate and they realised that the key to solve people's problem was in tackling their water problem. Thus began rural development work in 1972 with emphasis on providing safe drinking water and irrigation for agricultural land.

From their earlier experiences, they found that merely providing education about nutrition and other aspects of health care was not able to make a real dent in the existing problems. So the methodology employed was to concentrate on solving the water problem by various methods of water conservation with people's participation in the programmes. Today the village development programmes and employment generation programmes outweigh medical components. In fact, the direct medical work is confined to hospital services with priority to those who come from project villages.

**Activities and Achievements :**

In the beginning, water-borne diseases were rampant. Out of the 20 beds of the hospital, 10 to 15 were usually occupied by typhoid patients. Besides that, hepatitis, gastro-enteritis and guinea-worm infestations were prevalent. Thus, with an OXFAM grant of Rs.28,000 the MAM undertook repairs of wells. Most of the wells were having stone ladders (step-wells). They were changed so that water contamination was minimised.

The total population covered by the MAM outreach programme is about one lakh. The project covers 25 to 30 villages in the Haveli taluka of Pune district.

It is difficult to enumerate in detail each activity carried out by the MAM. We mention some of them :

1. Rural Development work started with repairs of existing wells. This was followed by surface conservation of rain water by building small bandhs (mini dams or bandharas). Now there are three large percolation tanks and 22 small dams in the area. To increase water retention in the soil, contour cultivation practice and trenching on hill slopes was done in the area. Afforestation was taken up systematically. For this, the MAM discouraged cutting of trees and distributed saplings. The achievements in this field are very significant. Today 1200 acres of land is irrigated, large number of pump-sets are found in the fields and drinking water is available in all the villages.
2. This experience has been utilised for land development by other NGO projects. The MAM has drilled wells in Andhra Pradesh, Uttar Pradesh, Saurashtra (Gujarat) and Tamil Nadu.
3. The MAM started a Montessori school which has subsequently grown into a primary school with over a thousand students. The school does not receive government grants, so a fee of Rs.20/- per month is charged from students.
4. The Mandal runs an orphanage with 45 children.
5. A Farmers' Co-operative was started but failed.
6. It has sponsored a co-operative housing society with 80 members.
7. MAM sponsored a co-operative bank in 1978 and is successfully operating it. It has 5500 members with a share capital of Rs.28 lakhs.

8. For training in technical skills, it manages a workshop.

9. In Thane and Pune districts, it installed 150 gobar gas plants, mostly in tribal area.

10. It has a mobile library with about 8500 books.

11. The Mandal helped in building about 27 kms of roads in the area.

12. The Mandal had its own hospital in Ambejogai (Dist: Beed) managed by Dr. Lohia. Now it is a separate project headed by Dr. Lohia. (See profile on Manavlok).

13. A training-cum-production centre for poor, needy and destitute women.

14. In 1966-67, family planning work was undertaken by the MAM with financial assistance from the government. Every year the Mandal conducts about 2000 tubectomies and a handful of vasectomies.

**Finances :**

For its various programmes in the last two decades, the MAM has received or is receiving funds from many agencies. To name some of them : Arbeiter Wolfahrt (West Germany), OXFAM (U.K.), Christian Aid (U.K.), Catholic Relief Services (U.S.A.), Agro Action (West Germany), Food for Work Programme (Government), Social Welfare Department of the government and so on.

The MAM does not allow its full-time doctors to do private practice. The honorary doctors are not allowed to practice in Hadapsar. All the incentive monies to the staff (e.g.: family planning) go to the MAM. In fact, the incentive money contributed a part of the expenditure in constructing the hospital building. The highest salary received by any official of the Mandal is not allowed to exceed 8 times that paid to the lowest paid worker.

The total budget of the MAM is about Rs.40 lakhs. Less than 10% (Rs.3 lakhs) comes from the government. But no grant is received from the government for the school, social forestry and rural development. The social welfare department gives Rs.95 to Rs.100 per month per child for the MAM's orphanage. The family planning programme is entirely funded by the government.

## 31. SEVADHAM, PUNE

**Name and Address of Project** : Sevadham Trust, C/o Manoj Clinic,
1148 Sadashiv Peth,
Pune 411 030.

**Project-in-Charge** : Dr. S.V. Gore

Sevadham has been actively working in Maval taluka of Pune since 1980. The project is working mainly in the tribal area of this taluka. The project is still in the stage of firmly establishing itself. As regards its health programmes, the project has adopted a community approach since early 1985. Female health workers have been trained and they work on a purely honorary basis. The project is now being supported by USAID.

**Aims and Objectives :**

The project was started mainly because the project-holder was moved by the rural-urban

differences, especially in such close proximity to an industrial area. The main objective thus was to narrow this gap between rural and urban areas through health and education programmes.

**Social Geography :**

The Ander Maval area represents a transitional zone between the wet Konkan lowland in the west and drought prone uplands of the east (deccan plateau). The area is mostly comprised of hilly tracts with meagre road communications.

Maval taluka has a tribal population of about 9%, but the area that the project is working in is mainly tribal. The average household size is 5.8 persons and the sex ratio is 949 females per 1000 males. The literacy rate is 35.5% (20.4% female) and the non-workers constitute 57% of the population; of the workers only 10% are agricultural labourers.

The main health problems in the area are gastro-intestinal infections, worm infestation, scabies and protein-vitamin deficiency. Very recently a base line study was being undertaken.

**Organisation and Methodology :**

In one village the project runs a dispensary which is being converted into a health centre. Occasionally medical treatment and diagnosis and immunisation camps are held in surrounding villages where the project is undertaking other activities or is trying to establish a base for community health work. CHWs have been trained recently for 24 villages and seven subscentres have been established which are covered by a mobile team twice a week.

The project's educational programme is well established with six Balwadis and a school. Health and family planning education campaigns are occassionally organised.

As of present in the project there are three doctors, three nurses, an extension educator, four Balwadi teachers and 24 health workers besides the project director and other administrative staff.

**Activities and Achievements :**

The dispensary is run by a doctor with the assistance of a nurse and a voluntary social worker. Its monthly attendance is about 500 patients. Medical camps were conducted occasionally in villages to promote immunisation and to establish their base by providing curative services. Occassionally health education exhibitions were also held. Since the USAID grant the scope of activities has enlarged substantially with regular mobile teams visiting each of the seven subcentres twice a week to undertake mass immunisations against DPT, polio and TB (BCG).

Mahila Mandals have been formed, through which health education is imparted to women, especially regarding ANC/PNC and child care. The ANC/PNC programme is run by the village health workers and it is free of cost. However for curative services the health workers charge Rs.4/- per ailment till it is cured.

So far there are four Balwadis being run by the project. Through the Balwadi a nutrition programme is run for under fives providing high protein substitutes - eggs three times a week and khichadi (rice is contributed by villagers) three times a week. The project also runs a free hostel for those students who are in secondary school. It also provides scholarships, books and assistance in getting admission

to schools. The project has been carrying out ground-water surveys to increase community water resources; wells are dug with the assistance (Shramdan) of villagers.

The project is planning a massive expansion of both health and educational programmes as well as taking on other agricultural developmental projects.

**Finances :**

The project was earlier funded through voluntary donation but since 1985 they are receiving assistance from USAID and as a result have been able to expand their health activities considerably. Information about expenditure was not available.

## 32.* SOCIAL SERVICE SOCIETY OF THE MEDICAL MISSION, SHEVGAON-NITYASEVA HOSPITAL

**Name and Address of Project** : Community Health & Development Programme of Nityaseva Hospital, Shevgaon, Dist: Ahmednagar.

**Project-in-Charge** : Sr. Theresia Ohlig

The Nityaseva hospital is an 80 bed institution with sophisticated facilities for medical, surgical, gynaecological and obstetric cases. It is run by sisters of the Medical Mission since 1974. Soon it was realised by the conscientious staff of the hospital that hospital services were not accessible and available to the poorest sections and they felt uneasy about this fact; and that most diseases encountered were of a preventable nature.

A survey was carried out and it was revealed that 75% of illnesses were preventable, that more than 60% of cases coming to the hospital were from beyond a distance of 5 kms., that 50% of those who took advantage of hospital facilities were educated, and that 60% of hospital patients had annual incomes exceeding Rs.3,000/-. The implications were clear that the hospital, a charitable institution established to reach the poor and underserved, was least utilised by the illiterate and poor - and mainly for illness that were preventable.

This situation prompted the sisters to start an outreach health programme in 1978. Currently the project covers 11 villages (excluding Shevgaon) with a population of 10,410.

**Aims and Objectives :**

The community health programme was started to achieve the objective of providing health for all, especially the poor and uneducated, in remote areas and villages where other health care facilities were not available. This was to be done through both preventive and curative health care services that were to be made available to the villagers within their own village by their own people.

**Social Geography :**

Most of the project villages are in the interior and therefore access is difficult and public transport lacking. Information on electricity supply, literacy and cast/community composition, landholding and irrigation facilities, was not available for the project villages.

Shevgaon like most Ahmednagar talukas is completely rural. It has not yet received the benefits of the sugar farming areas. It is located between two developed talukas-Ahmednagar taluka and Paithan taluka of Aurangabad district. Shevgaon has a population 1,38,275 spread over 25,971 households making for an average household size of 5.3 persons and a sex ratio of 984 females per 1000 males. The scheduled castes constitute 14.2% of the population and the literacy rate of the population is 37.6% (22.6% female). Agricultural labourers constitute 34.6% of the work force (54.2% female) and non-workers constitute 51.2% of the population.

Only those villages were selected by the project where the gram panchayat assured complete co-operation and assistance.

**Organisation and Methodology :**

The Nityaseva hospital is the administrative and referral centre of the community health programme. The hospital as indicate earlier, has good medical care facilities and the charges for the services are reasonable, directly proportional to income of the patient.

At the village level are village health workers (all female). In the 11 villages there are 20 VHWs. The CHWs, selected from their villages, received initial training in treatment of minor illnesses and first aid; handling of major diseases such as leprosy, tuberculosis, jaundice, typhoid, cholera, scabies and malaria; prevention of deficiency diseases; child care, ANC/PNC, delivery nutrition education and social awareness. The training is a continuous process through fortnightly meetings at the centre in Shevgaon. The CHWs are paid Rs.50/- per month.

The CHWs are supported by a mobile team of a doctor, a social worker and 2 ANMs. Each village is covered once a wekk to provide services that the CHW cannot provide, and to follow-up the work of CHWs.

The project maintains a visible relationship with government agencies and is collaborating with the government in the tuberculosis programme. All T.B. drugs and vaccines are provided by the government agencies to the Nityaseva hospital which is a recognised T.B. subcentre under the National Tuberculosis Programme. Also other vaccines and Vitamin A doses are supplied by the government.

The project insists on a certain amount of participation from the community if their village is to be included in the community health programme; this means providing a place for a clinic and caring for its maintenance, support to the CHWs' activities and health education, and active support of the programme by the panchayat.

**Activities and Achievements :**

The project through its mobile team and CHWs provides the following services : ante-natal and post-natal care, home deliveries by CHWs, child health education and nutrition programme for under and malnourished children, immunisation programme (T.T., BCG, Triple, Polio, Cholera, Typhoid, Vitamin A), treatment of minor ailments by CHWs, weekly mobile dispensary, T.B. detection, follow-up and treatment, social and health education (audio-visual).

The project has also made efforts in establishing youth clubs and Mahila Mandals, balwadis, providing assistance in taking advantage of government schemes (IRDP, etc.), agricultural programmes for improved farming and construction of community wells.

Being a Catholic Mission the project does not provide family planning services but it has trained CHWs to provide education in family planning.

The project conducted an evaluation in 1981 and the following results emerged; immunisation coverage (for all vaccines) increased to 70.5% of all under fives in 1981 from 3.7% in 1977; 73% of pregnant women received ante-natal care instead of 19% in 1977; in 1981 3.2% of new borns died in the first year of life as against 43% in the first two years of life in 1977; school attendance of children increased from 65% in 1977 to 85% in 1981.

The project plans to gradually extend its outreach programme, encouraged by the impact that it has been able to make in the community.

**Finances :**

The community health programme is funded entirely by IGSSS, a German church agency and CRS (another Catholic agency that provides food for nutrition programme). In the calender year 1982 the project spent Rs.43,976 on its community health programme making for a per capita expenditure of Rs.4.22. Out of this 47.7% was spent on salaries, 15.7% on MCH, 30% on treatment and the rest on other programmes (This expenditure excludes hospital expenditure and agricultural and development programmes). The village health services are provided free of cost. The agricultural development programmes are supported by the Swiss Development Corporation for Agricultural Development through the Social Centre, Ahmednagar.

## 33.* VADU RURAL HEALTH PROJECT

**Name and Address of Project** : Vadu Rural Health Project,
K.E.M. Hospital Research Centre,
Sardar Mudaliar Road,
Rastha Peth, Pune 411 011.

**Project-in-Charge** : Dr.(Mrs.) Banoo J. Coyaji

The Vadu Rural Health Project was started in January 1977. It is one of the well-known and well documented projects in Maharashtra. It's experiment in implementing primary health care approach through communith health workers, along with experiments by other projects, influenced greatly in formulating the national policy to achieve Health for All by 2000 A.D.

**Aims and Objectives :**

The stated objective at the commencement of the project was to provide comprehensive health services in rural areas. This objective has not undergone any fundamental change so far. However, in providing comprehensive health services through the primary health care approach, emphasis is now on community participation and involvement by making them self-reliant.

**Social Geography :**

The project covers 19 villages (now 22 as per 1981 census) with 35,642 population (1983 mid-year estimate) in Sirur and Haveli taluka of Pune district. The important reasons for selecting this area were :

(1) it is a drought area; and (2) it is socio-economically backward. The agency did not encounter any major difficulty in finding entry into the area because in Vadu the Primary Health Unit was already providing curative services, so the centre was already known to the people. The Zilla Parishad and villagers responded positively, encouraging and helping the agency in establish this project.

In the beginning a base-line survey was conducted in the project area by the agency. The agency identified the main causes of morbidity as being upper and lower respiratory tract infections, skin diseases (particularly scabies and fungal infections), diarrhoeal disease, fevers, disorders of the genio-urinary tract, otitis media, anaemia etc. In 1977, the death rate was 13.1 per 1000 population.

The current (1984) death rate in the project area is 8.9 per 1000 (dejure) and birth rate is 30.3 per 1000 (dejure). The infant mortality rate is 75.0 per 1000 live births.

In the project area, 50.3 percent of the population is literate; 8% of the work force is that of landless agricultural workers; 46% landholders have 5 or less than 5 acres of land; 20 villages are electrified and 17 have access to public transport within one km. The project area has totally 22 private medical practitioners.

**Organisation and Methodology :**

Under a tripartite agreement with the Government of Maharashtra and the Pune Zilla Parishad the K.E.M. Hospital has been given the technical and administrative control of the orginal Primary Health Unit at Vadu. Thus, the K.E.M. Hospital is working with the government system since inception and the staff of the Vadu Rural Health Project are, by and large Zilla Parishad/Government Staff who are under the control and supervision of K.E.M. Hospital for day-to-day activities. The Zilla Parishad staff consists of male and female MPWs in each of the six sectors and two Health Assistants and a Medical Officer with an ANM at the headquarters in Vadu. There are also 39 Community Health Guides (20 male + 19 female), one male and one female CHG per village. The Director of Community Medicine, the Project Administrator and the Health Supervisor of K.E.M. Hospital are responsible for organising health care activities and for demonstrating effective health care delivery through alternative approaches.

The CHGs were selected in close consultation with villages, the panchayat and the Zilla Parishad. They were given initial training for three weeks which was later followed by two retraining programmes of 6 days each. The main functions performed by the CHG are in connection with the following programmes : (1) Health Education; (2) MCH; (3) Immunisation; (4) Family Planning; (5) Nutrition Education; (6) Control of Communicable diseases; (7) Environmental sanitation; (8) Treatment of Minor Ailments and first aid. Here the CHG acts as an interface between the regular health infrastructure and the community and also acts as a facilitator in the implementation of health programmes.

The organisational strucutre has recently undergone some changes. The Vadu Rural Hospital with 30 beds serves as the first level referral centre and now has 2 Medical Officers, one Health Supervisor, 2 ANMs, one Compounder, one wardboy and one ayah. There are 12 MPWs - one male and one female in each of the six sectors. At the grassroots level there are 39 Community Health Guides distributed in the 22 villages.

The K.E.M. Hospital, Pune is the apex institution which provides all support services including guidance, specialist and emergency services.

The methodology rests on the conviction that within existing structural constraints and by applying the primary health care or community health approach in a sicentific manner yet ensuring people's involvement and participation, the health services can be oriented towards the people to make them self-reliant and at the same time the efficacy of programme implementation can be augmented. Health education is an important component in this approach and methodology. In this task the agency has benefitted by the support given by the directors who originally belonged to the highest echelons of the Government health cadre.

With the setting up of Vadu Rural Health Project the K.E.M. Research Centre, which had already been carrying out clinical and laboratory research, extended its activities to health services research. The Research Centre now has a senior demographer, a senior statistician and a senior social scientist and a number of field staff like medical social workers working at the gross-root level, and also other research staff. It is headed by the Director of Research. The field operational research activities are not only carried out in the Vadu Rural Health Project area but also in the adjacent Kendur-Nhavra Primary Health Centre area. There are also other research activities such as studies on Indian Childhood Cirrhosis, injectable contraceptive trials etc., which are carried out by the Research Centre.

**Activities and Achievements :**

Primary health care, first aid, ante-natal, natal, post-natal care to pregnant women, infant and child care, family planning guidance, nutrition education and health education, measures regarding control of communicable diseases as well as know how on personal hygiene and improvement of environmental sanitation are provided right in the village through CHGs. The CHGs are supported by the regular field staff under the health infrastructure, the Vadu Rural Hospital and the K.E.M. Hospital. The CHGs do not charge for the services (as in the case of the government sector), while at Vadu Rural Hospital patients are charged nominally.

In 1984, 91 percent of identified pregnant women (i.e. 1570 out of 1720) received ante-natal care. Out of the 1570 pregnant women registered, 55.1 percent received the first dose, 44.6 percent the second dose and 21.5 percent the booster dose of Tetanus Toxoid. Out of the total 942 deliveries conducted in 1984, 60.8 percent were conducted by relatives, 14.1 percent by traditional dais (untrained), 4.6 percent by trained dais, 6.0 percent by ANMs and 14.5 percent at the Vadu. Rural Hospital, K.E.M Hospital or other hospitals. In 1984 the agency distributed 704 presterilised delivery packs each costing less than two rupees each.

The infant mortality rate showed a sharp fall of 32.4 points from 107.4 in 1978 to 75.0 per 1000 live births in 1984. The neo-natal mortality was 50.5 per 1000 live births in 1984.

The family planning programmes are an integral part of their activities. In 1984, 16 vasectomies and 326 tubectomies were performed.

The project collaborates with the socio-economic and research programmes of a sister organisation known as UNDARP.

**Finances :**

The project is funded by the Government of Maharashtra, the Pune Zilla Parishad and the K.E.M. Hospital, Pune. In the year 1983-84, the agency spent Rs.1,87,272, out of which 22.5% and 32%

of the expenditure was incurred by the Government of Maharashtra and the Zilla Parishad, Pune respectively while 45.5% was contributed by the K.E.M. Hospital, Pune. In addition, the project is receiving funds from the Ford Foundation and ICMR.

The share of the K.E.M. Hospital in the total expenditure comprises of :

1. Additional honorarium of Rs.75/- to each CHG over and above Rs.50/- paid by the Government.
2. Extra medicines to Vadu Health Centre and the CHGs.
3. Transport.
4. Other contingent expenditure.

The Vadu Health Centre collected Rs.11,822.30 through outpatient fees in the year 1983-84.

## 34. VERALA IRRIGATION AND DEVELOPMENT PROJECT SOCIETY

**Name and Address of Project** : Verala Irrigation and Development Project Society,
Laxmi Nivas, Ambarai Road,
P.B. No: 49, Sangli 416 416

**Project-in-Charge** : Arun Chavan

This project is primarily a rural development project with no direct activities in the field of health care. Therefore, the entry point was not health programmes but community development programmes. It was started in October 1969, covering 2 villages and a population of 4,000.

**Aims and Objectives :**

The objectives at the commencement of the project were :

1. To increase productivity of agricultural land;
2. To provide infrastructure for improvement in quality of life such as educational facility, electrification, road communication;
3. To provide employment;
4. To introduce better farming practices and
5. To organise farmers for self-help.

The objectives have undergone change by now. The present objectives emphasise on comprehensive area development with social justice. Emphasis is also on organisational and educational aspects and group activities. The social health programme and non-formal education among the younger persons from the under-privileged groups are being emphasised.

**Social Geography :**

The agency covers 20 villages with 40,000 population in Sangli district of Maharashtra. The villages do not form a continuum but form two clusters, each located in a separate block. The villages are located in a semi-arid region.

As per the data provided by the agency, the dominant caste in the project villages is Maratha, constituting 70% of the population while Harijans (of all sub-castes) are 11% of the population. The literate population (25%) is far below the average for the state (47%) and that for Sangli district (47%). Only 1% of the workers are landless agricultural workers and 30% of agricultural workers own land. 25% are small/marginal (upto 5 acre) cultivators. Half the population is facing scarcity of drinking water supply. The villages have electricity and public transport facilities. There are seven private medical practitioners in the area.

Main crops in the villages are hybrid jowar, sorghum, groundnut, sugarcane and wheat. 4% of cultivable land has irrigation available for a second crop (wheat).

These villages were selected for their drought prone conditions and the co-operation offered by the local leadership. The entry point was provided by two local activists with sound background of public work and experience during the struggle for India's independence.

**Organisation and Methodology :**

The project-in-charge is a full-time honorary secretary. The field staff consists of field organisers and their assistants. In the first year of the project (1969-70), the agency employed one field organiser and 3 assistants to manage its food-for-work programme. Presently, the agency has 6 field organisers conducting various programmes.

No baseline survey was conducted at the time of commencement. The agency keeps full data on certain projects like small farmers' development project, orientation and group activities. But no evaluation - external or internal of the project has ever been done.

The agency has not outlined separately its methodology and approach in its report. From the review of its activities the methodology appears to be one of acting as catalysts for providing irrigation, forming co-operative farming societies, afforestation, and constructing school buildings. It also organises orientation courses for farmers, farmers' study tours and discussion camps.

**Activities and Achievements :**

In its one and a half decades of work, the agency has undertaken numerous activities. Some of them are : construction of 250 irrigation wells for small farmers, constructing 19 Gobar gas plants, built 10 km. of roads, built 3 percolation tanks, one high school building, extension of primary school buildings, providing lift irrigation facilities, planting of thousands of trees, running nutrition programme for children, distribution of seeds and fertilisers to the poor farmers, and so on.

During the scarcity year, the agency managed a labour intensive development programme employing 2,225 workers per day. The total employment generated was 800,000 man-days. The agency also helps farmers to get loans for agricultural development from commercial banks and funding agencies. With the encouragement from the agency in 1982, ten seedless grape vine-yards were planted.

The agency also conducts educational programmes. In 1979-80, it operated the National Adult Education Programme of the Indian government. It has also opened three libraries in villages.

In its above activities, the agency has reported two main problems. The first is political. The agency's work is independent of political parties. Two panchayat samities in the area and the Zilla

Parishad are controlled by the Congress (I) party. According to the agency, this party is unsympathetic to the agency's work. Secondly the caste structure hampers unified action in the community.

**Finances :**

For the two on-going projects funds come from the Protestant Central Agency for Development Aid and the remaining come from Freedom from Hunger Campaign, West Germany.

The other funding agencies which provided grants or loans include, AFARM, NAEP, Deutche Welthungarchilfe, (West Germany), AFRO, TROCARE, (Ireland), EZE (Bonn), Terre des Hommes, Bank of India (loan), OXFAM, CASA, Bread for the World, West Germany, Christian Aid U.K., Community Aid Abroad, (Australia) and Khadi and Village Industries Board.

The agency's balance sheet as on 30th June 1983, shows that the agency received total grants of nearly 16.5 lakhs rupees. The percentage contribution of different funding agencies was: PCADA 72%, EZE (West Germany) 16%, TROCARE (Ireland) 8%, Government of India (Rural Development Ministry) 1% and the rest contributed by AFARM, NAEP, AFRO, Sistership Community Committee etc. The agency received total loans of about 1.5 lakhs - 61% coming from Bank of India, 36% from OXFAM and the rest from CASA.

Information on details of expenditure was not available.

## 35. WANLESS HOSPITAL, MIRAJ PROJECT

**Name and Address of Project** : Wanless Hospital,
Miraj, Sangli District.

**Project-in-Charge** : Dr. Kalindi Thomas

The Wanless hospital is a teaching institution with sophisticated health care facilities. The hospital is a Christian charitable organisation providing health care at a concessional rate as compared to other private medical establishments.

Wanless Hospital's Community Health Programme was started in 1977 in four villages of Miraj taluka. The population covered was 20,000. Their area of coverage as of date remains the same. The project started with a preventive health focus but over the years has diversified into socio-economic programmes.

**Aims and Objectives :**

The project began its outreach programme mainly to promote preventive health care. Thus their objectives are :

1. Immunisation with BCG, DPT, Polio, TT, for all under-fives.
2. Ante-natal care, including immunisation of all pregnant women.
3. Training of mid-wives (dais) and their incorporation into the health structure.
4. Health and Nutrition Education through home visits and through Mahila Mandals.
5. Supplementary feeding programme for under-fives through balwadi.

6. Nutrition and sanitation training to all mothers.

Later on it was realised that in the absence of socio-economic development health has little meaning. Therefore, today socio-economic programmes constitute an important focus. The programmes are not individual but community oriented being run through Mahila Mandals and Youth Clubs.

**Social Geography :**

Miraj is a highly developed taluka due to sugarcane farming and adequate irrigation facilities. Wanless Hospital selected this area for their community health project, firstly because of easy access and second, because they were known in these villages through their curative medical camps. Miraj is a highly urbanised taluka with 53% of its population living in urban areas; as a consequence social and economic infrastructual facilities are well developed and proliferation of urban influence in rural Miraj is substantial. The rural literacy rate is 49.3% (36.4% for females), the average rural household size is 5.53 persons and the sex ratio 929 females per 1000 males.

The proportion of non-workers in the population is 66.3% (61.3% for rural areas). Out of the main workers in rural areas agricultural labourers constitute 19.88% (39.4% female). The schedule caste population is 12.65%.

All the four villages of the project have electricity and easy access to public transport and there is adequate potable water supply throughout the year. The project estimates the crude birth rate to be 18.85 per 1000 population and the crude death rate as 7.90 per 1000 infant mortality rate is 58 per 1000 live births.

The project villages cultivate three cash crops - sugarcane, tobacco and grapes, and 70% of the households in the project villages are landless.

The project area is highly caste-stratified with Marathas (30%), Jains (30%) and Harijans (20%) being the dominant communities. Harijans in the project villages are isolated as a group and as a consequence have their own Balwadi and Youth Clubs. The panchayat is split amongst two parties that freely indulge in cast politics. Women are kept out of the mainstream and the project finds it very difficult to establish Mahila Mandals that are active.

**Organisation and Methodology :**

The project is administered by the hospital; it is an outreach program of the Department of Social Medicine. Each village has a trained Community Health Worker (CHW) selected by the project on the recommendation of the panchayat. The training (3 months duration) of the CHWs was organised in collaboration with the government. The CHWs work is related to five defined areas :

1. Maternal and child health;
2. Family planning;
3. Nutrition and health education;
4. Immunisation; and
5. Curative services

The CHW receives Rs.50/- per month from the project.

The dais (16 in 4 villages) constitute an equally important component of the project's health structure. Traditional dais of the villages were identified by the project and were given training in proper and hygienic delivery practices; they have been trained to provide health education to mothers and maintain delivery records.

These village-level workers are supervised and supported by paramedics (nurses and social workers); at the apex is an MPH trained doctor (project-in-charge), an MBBS doctor and a nutritionist. They visit the project villages periodically. The referral base is the hospital itself (villages covered range between 6 and 30 kms. from Wanless Hospital), where sophisticated health care is available at a concessional rate.

**Activities and Achievements :**

In keeping with their objectives, the range of activities undertaken by the project include regular under-five and MCH clinics, general medical care, mass immunisation and health camps, school health programme, construction of latrines, film and audio-visual shows, surveys and dai training programme.

With the addition of socio-economic programmes in their objectives the project has undertaken tree planting (Nilgiri, Subabul, Coconut, Sag and Lime), training in poultry farming in collaboration with the government, training of balwadi teachers, organisation of women into Mahila Mandals and mothers' clubs for nutrition and health education and tailoring classes, first aid training to primary school teachers, and cultivation of vegetables on demonstration plots to increase vegetable growing which will support the success of their nutrition programme.

The project maintains the following data through its recording system : ANC, delivery and PNC, immunisation, types of diseases, school health surveys, family planning, health education material, daily work records and medicine disbursement records.

Some of the major illnesses in the project area identified include leprosy and tuberculosis; xeropthalmia, diarrhoeal diseases and nutritional deficiency among children, and respiratory ailments, ulcers, nutritional deficiency and debility among adults.

**Finances :**

The project is entirely funded by the Wanless Hospital. The Zilla Parishad provides only vaccines for the community health project.

The 1984 budget is as below :

| | | |
|---|---|---|
| (a) | Health and related activites | 32,000 |
| (b) | Non-health activities | 15,000 |
| (c) | Staff salaries | 40,000 |
| (d) | Programme materials | 5,000 |
| (e) | Transport and overheads | 8,000 |
| | TOTAL | 1,00,000 |

## VIDHARBHA REGION


Like Marthwada Vidharbha is a neglected region and is highly backward. Territorially it is the largest region and is socio-culturally quite distinct from the rest of the state. The region includes the districts of Nagpur, Wardha, Chandrapur, Gadchiroli, Bhandara, Buldana, Yavatmal, Akola and Amravati. A special feature of this area is the large number of Gandhian institutions. It is indeed the poorest region of the state having the least political bargaining power.

## SOCIAL, ECONOMIC AND HEALTH INFORMATION : VIDHARBHA REGION DISTRICTS

| Districts | Population (Persons) 1981 | Urban Popuin. (Percent) 1981 | % Area of State 1981 | Density per km. (Persons) 1981 | Average Household Size (Persons) 1981 | Popuin. Growth 1971-81 (Percent) | Literates (Percent) 1981 | Female Literacy (Percent) 1981 | Sex Ratio (F/1000M) 1981 | SC Popuin. (Percent) 1981 | ST Popuin. (Percent) 1981 | SC as % of State 1981 | ST as % of State 1981 | No. of Villages |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Buldhana | 1508777 | 18 | 3.1 | 156 | 5.32 | 19.46 | 44.64 | 29.97 | 957 | 6.18 | 4.40 | 2.08 | 1.15 | 1273 |
| Akola | 1826952 | 25 | 3.4 | 173 | 5.41 | 21.68 | 47.82 | 35.45 | 948 | 5.51 | 6.28 | 2.25 | 1.99 | 1546 |
| Amravati | 1861410 | 29 | 4.0 | 152 | 5.31 | 20.78 | 51.82 | 42.55 | 936 | 6.06 | 12.98 | 2.52 | 4.19 | 1698 |
| Yavatmal | 1737423 | 15 | 4.4 | 128 | 5.26 | 22.04 | 39.39 | 26.86 | 958 | 4.95 | 21.30 | 1.92 | 6.41 | 1751 |
| Wardha | 926618 | 25 | 2.1 | 147 | 5.07 | 18.86 | 51.05 | 40.53 | 948 | 3.93 | 15.35 | 0.82 | 2.46 | 1015 |
| Nagpur | 2588811 | 57 | 3.2 | 260 | 5.27 | 33.26 | 54.56 | 44.62 | 924 | 7.05 | 13.65 | 4.07 | 6.12 | 1658 |
| Bhandara | 1837577 | 13 | 3.0 | 199 | 5.20 | 15.89 | 43.92 | 29.49 | 997 | 9.75 | 16.22 | 4.00 | 5.16 | 1624 |
| Chandrapur (includes Ghadchiroli) | 2055642 | 13 | 8.4 | 79 | 5.13 | 25.33 | 34.69 | 22.22 | 966 | 6.53 | 26.73 | 3.00 | 9.52 | 2978 |

| Districts | CMIE Index Score 1980 | Main Workers (Percent) 1981 | Non-Workers (Percent) 1981 | Agricultural Labourers as % of main workers 1981 | Sex Ratio of Agric. Labourers F/1000 M 1981 | Ratio of Agric. Labourers to Cultivators (Percent) 1981 | % Main workers in Non-Agricultural sector 1981 | Average Size of Operational holding (hectares) 1976-77 | Per Capita Production of Food Grains (Kgs) Avg. of 1975-1980 | Avg. Daily Employment in Factories (Per 1,00,000 population) 1977 | Per Capita Bank Deposits (Rs.) 1983 | Per Capita Bank Advances (Rs.) 1983 | % Forests Area (Percent) 1973-74 | % Villages Electrified (Percent) 1984 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Buldhana | 72 | 47.0 | 49.4 | 43.91 | 1122.7 | 110.08 | 16 | 4.2 | 247 | 429 | 225 | 217 | 12 | 92 |
| Akola | 65 | 42.6 | 55.2 | 50.83 | 1027.2 | 177.04 | 20 | 4.2 | 179 | 611 | 369 | 363 | 7 | 89 |
| Amravati | 93 | 40.5 | 57.0 | 52.61 | 932.8 | 215.47 | 23 | 3.6 | 166 | 505 | 411 | 243 | 29 | 91 |
| Yavatmal | 62 | 46.0 | 51.1 | 53.47 | 1133.7 | 176.67 | 16 | 5.5 | 192 | 418 | 243 | 176 | 18 | 95 |
| Wardha | 84 | 42.9 | 54.8 | 47.99 | 1155.1 | 165.76 | 23 | 4.6 | 209 | 866 | 430 | 266 | 11 | 91 |
| Nagpur | 110 | 35.6 | 61.8 | 26.25 | 1255.7 | 126.14 | 53 | 4.1 | 106 | 1524 | 1314 | 652 | 18 | 91 |
| Bhandra | 72 | 45.7 | 49.5 | 27.07 | 1137.3 | 59.72 | 28 | 2.0 | 216 | 196 | 212 | 112 | 27 | 81 |
| Chandrapur (includes Ghadchiroli) | 59 | 42.8 | 50.0 | 30.20 | 1247.3 | 64.60 | 23 | 3.4 | 227 | 481 | 332 | 140 | 56 | 55 |

| Districts | Voluntary Hospitals 1979 | Govt. Local Body Hosp. 979 | P H C S 1983 | P H C S 1984 | Rural Hosp. 1984 | B C G Vaccination 1983-84 | DPT Vac. 1983-84 | Polio Vac. 1983-84 | T.T. Mothers 1983-84 | T.T. Upto 16 years 1983-84 | Tubectomy 1983-84 | Vasectomy 1983-84 | IUDs 1983-1984 | Estimated Eligible Couples 1983-84 | Couples Currently protected by 1983-84 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | Steri-lisation | IUCD | Other Method |
| Buldhana | 10 | 11 | 13 | 41 | 5 | 73199 | 89122 | 58280 | 48756 | 68067 | 8618 | 6348 | 21365 | 273000 | 96682 | 17531 | 11040 |
| Akola | 19 | 12 | 14 | 48 | 4 | 90894 | 118517 | 51671 | 80936 | 71728 | 11827 | 12189 | 29016 | 320000 | 143958 | 23435 | 10014 |
| Amravati | 24 | 14 | 17 | 48 | 5 | 77642 | 75288 | 42056 | 42457 | 48325 | 10452 | 12619 | 25740 | 308000 | 145776 | 21495 | 11685 |
| Yavatmal | 11 | 10 | 20 | 53 | 6 | 65961 | 91943 | 52632 | 56249 | 43904 | 13449 | 5159 | 4259 | 312000 | 126394 | 18315 | 11451 |
| Wardha | 9 | 6 | 8 | 23 | 4 | 50022 | 36457 | 244429(?) | 24986 | 25127 | 5215 | 3849 | 22172 | 158000 | 47812 | 3860 | 4376 |
| Nagpur | 18 | 23 | 13 | 40 | 5 | 73438 | 75709 | 62146 | 58891 | 53338 | 11065 | 11958 | 20538 | 468000 | 189215 | 20035 | 10816 |
| Bhandara | — | 8 | 19 | 63 | 7 | 70505 | 79046 | 42056 | 43082 | 55587 | 6285 | 11048 | 15145 | 350000 | 131216 | 12612 | 12666 |
| Chandrapur (includes) Ghadchiroli) | 9 | 5 | 32 | 92 | 8 | 91523 | 117023 | 63050 | 54479 | 64115 | 10912 | 15766 | 19834 | 396000 | 165881 | 16281 | 15745 |

Sources : Compiled from :

1. Census of India: 1981, Series - 12, Maharashtra, Primary Census Abstract Part II-B, Govt. of Maharashtra, Bombay, 1983.
2. Profiles of Districts, Part I : A-K, Part II : L-Z, Centre for Monitoring Indian Economy, Bombay, 1985.
3. Performance Budget, 1985-86 - (a) Family Welfare, (b) Medical (Non-teaching Hospitals), (c) Public Health and Sanitation, Government of Maharashtra, Aurangabad, 1985.

## 36.* ANANDVAN

**Name and Address of Project** : Maharogi Seva Samiti,
P.O. ANANDVAN 442 914
Tal: Warora,
Dist: Chandrapur

**Project-in-Charge** : Baba Amte

Maharogi Seva Samiti was formed in 1950 by Murlidhar Devidas Amte at Anandvan.

**Aims and Objectives :**

The Maharogi Seva Samiti works for the eradication of leprosy. Anandvan was started as a treatment centre and home for leprosy patients. Many of its activities are organised around its objective to give self confidence to and rehabilitate leprosy patients.

**Social Geography :**

The project was started in Warora on 25 hectares of land received from the Madhya Pradesh Government and 80 hectares from the Maharashtra Government. Today Anandvan is spread over about 450 acres. The agency over the years established three more projects, Ashokvan (1957), Somnath (1967) and Lok Biradari (1973).

Chandrapur is a highly backward district in Maharashtra with more than a quarter of its population being tribals. Urbanisation is very incipient with only 13% of the population being urban and only 35% of the population literate. The working population is 43% and out of this 47% are cultivators and 30% agricultural labourers.

Warora Tehsil is also equally backward having 26% tribal population, a literacy rate of 44% and only 41% of the population constituting workers. Of the main workers agricultural labourers constitute 41% and cultivators 36%. Urbanisation is slow with only 10% population residing in urban areas.

**Organisation and Methodology :**

The agency is headed by a managing committee consisting of 18 members. We do not have detailed information on the organisational structure of this vast project.

It's methodology is based on the conviction that leprosy patients who are regarded outcastes and declared "dead" by society can, given the opportunity, live a better life in as creative a manner as any other human being.

**Activities and Achievements :**

**A. Anandvan :**

The agency carries out numerous activities. Some of them are as follows :

1. **Hospital :** There were 1,182 leprosy patients in the hospital as on 31st March 1984. The out patient department treated 1,464 patients in the year 1983-84. The hospital is also carrying out trials of the multidrug regimen on 250 patients.

2. **Maternal and Child Health Clinic :** In 1983-84, about 6,000 persons took treatment in this clinic.

3. **Sandhi Niketan :** This provides training to physically handicapped individuals. In 1983-84, there were 56 such persons under training.

4. **Andh Vidyalaya :** This is a school for the blind. In 1983-84, 68 (43 males and 25 females) students were studying in this school. In addition, recently the agency has started an educational programme for the deaf and mute children.

5. **Uttarayan (Home for Senior Citizens) :** 20 persons stay in this home and also help in the work of the project.

6. **Gokul and nursery :** This houses 8 orphan children and 36 children of leprosy patients.

7. **Agricultural activities :** In 1983-84, agricultural production was of about Rs.5.5 lakhs. In addition the project has a dairy and a poultry.

8. **Colleges :** The agency runs (a) the A.N. College of Agriculture and (b) a science college. About 2,000 students take education in these colleges.

Besides, the agency organises events like Anandvan Mitra Mela, tree planting, Shrama Sanskar camps and other socio-cultural programmes.

**B. Ashokvan :**

It is located on 100 acres of land. There are 75 leprosy patients engaged in agricultural activities and agro-industries. It is also a treatment, training and rehabilitation centre for leprosy patients.

**C. Somnath :**

This project has 1,300 acres of land. There are about 475 leprosy patients engaged in agricultural activities and agro-industries. It's activities include a non-formal manpower training centre for socially retarted groups and the physically handicapped, modern farming, seed production, horticulture, dairy and poultry and so on. In 1983-84, this project's production was worth Rs.7.22 lakhs.

In Somnath the agency also organises youth camps (Shrama Sanskar Chhavani).

Information on Lok Biradari has been given separately.

**Finances :**

The Government of Maharashtra, Department of Public Health gives Rs.600 per leprosy patient per annum tc the agency as grant-in-aid. The social welfare department pays Rs.250 per leprosy patient and for maintenance of the school for the blind, deaf and dumb and for the vocational training of 60 physically handicapped persons. The Department of Education gives grants for the colleges and schools.

In addition, other agencies like Action Aid, Terre Des Hommes and Swiss Aid, also give grants to the agency. Many such agencies have been helping the project through donations in kind.

The total income of the agency for the year 1983-84 exceeded Rs.80 lakhs out of which about 40% came from government agencies while more than 31% was internal income, i.e. income from sale of agricultural products, whereas the contribution through donation (both in cash and in kind, and from NGOs) was about 19% of the total.

In 1983-84, 22.5% of the income was spent on medical relief and more than 40% on education. Less than 2% of the income was spent on the Ashram's staff salaries.

The project's budget for the year 1985-86 is estimated to be of about Rs.1.15 crores.

## 37.* GANDHI MEMORIAL LEPROSY FOUNDATION

**Name and Address of Project** : Gandhi Memorial Leprosy Foundation, Hindi Nagar, Wardha 442 103.

**Project-in-Charge** : S.P. Tare, Director.

Gandhi Memorial Leprosy Foundation (GMLF) is a scientific research association having leprosy as its focus. It is one of the pioneer organisations in the country evolving various methods of leprosy control, treatment, removal of social stigma, health education and so on. It is also one of the oldest organisations in this field, started as early as November 1951. It is named after Mahatma Gandhi and its initial cadres came from the Gandhian movement for the social and economic upliftment of the masses.

The Wardha project is one of five such projects run by the GMLF in various states. Apart from the Wardha project, other projects are : T. Narsipur in Karnataka, Mararikulum in Kerala, Chilakalapalli in Andhra Pradesh and Balarampur in West Bengal. Each of them is managing one Leprosy Control Unit (LCU) of the Leprosy Control Programme of the Government of India. The GMLF selected these areas primarily for the high prevalence of leprosy in the villages covered under these LCUs.

**Aims and Objectives :**

GMLF has been working since 1951 following four main operational philosophies :

1. GMLF will not confine its work to any local area to eradicate leprosy.
2. It will not do routine leprosy work merely to give relief to leprosy patients.
3. It will not engage itself in laboratory studies or highly sophisticated research confined to four walls but will do it in and with the community.
4. It will take up such work and evolve such patterns as will help others (government and private agencies) to expand work for better service to patients.

It's stated objectives are :

1. To detect and register leprosy cases;
2. To conduct survey, education and treatment; and
3. To control leprosy by using sulphone tablets.

No fundamental changes are made in these objectives in the last 35 years of its operation. This does not mean that the GMLF is not flexible enough to undertake research and activities in the newer fields. For example, they have not stuck to sulphone tablets alone but are also experimenting with multi-drug regimes.

**Social Geography :**

The Leprosy Control Unit at Sevagram is the first control unit started by GMLF in 1952, covering 36 villages around Sevagram with a population 17,588. At that time the prevalence rate of leprosy in that area was as high as 25 per 1000 population, it being the highest in Maharashtra State.

In 1975 the GMLF handed over 9 villages to the Government of Maharashtra. Thus it is now covering 27 villages with a population of 21,188 (1981). The present prevalence rate for leprosy is 8 per 1000 and in 1981, the incidence rate of new cases through a survey of the population (about 85% population was surveyed) was one per 1000.

The socio-economic profile of the project area, as indicated by the GMLF is as follows : The dominant castes in this areas are Harijans (29.4%), Kunbis (23.7%) and Telis (5.4%), while other castes constitute 41.4% of the population. About 45% of the population are literate. The landless agricultural labourers comprise 30% of the workforce. All the villages have electricity and access to public transport. The current birth rate is 23 per 1000 and death rate is 7 per 1000 population. The infant mortality rate in 1978 was 58 per 1000 live births. More than 35 private medical doctors practice in this area. The main crops grown in this area are cotton, jowar, wheat, tur, linseed and groundnut.

Compared to this the 1981 census data for this area (Wardha Tehsil) enumerates only 4% of the total population to be from the scheduled caste while 14% from the scheduled tribes. Literacy is higher for the tehsil population being 54% of the total population. The male-female differential of literacy is also significant; 64% of male population as compared to only 44% of the female population is literate. 40% of the population constitutes the workforce and 58% are non-workers (2% are classified as marginal workers). Of the total workforce, agricultural labourers form the highest category (47%) followed by cultivators (24%).

**Organisation and Methodology :**

In the first year of the project's operation (1951-52) a staff of 4 persons comprising of one medical officer, one trained leprosy worker, one clinic assistant and one peon was employed. The project did not take up medical work immediately. The staff approached villagers to conduct a survey. While doing the survey they organised and addressed meetings of villagers to explain their plan of work and sought people's support and participation in their programmes. As an outcome of this interaction, three outdoor clinics were started in Sevagram, Jaipur and Yesamba villages.

Presently, one medical officer, two paramedical workers and one more worker are working on the field project.

The GMLF started a Leprosy Referral Hospital in 1965. This hospital provides support to the field staff. It has 132 beds, an out-patient department, a full-fledged laboratory and a physiotherapy unit.

But providing efficient medical care alone for leprosy does not ensure people's participation in the agency's programmes. The high level of the community's consciousness about leprosy in this area is due to continuous health education of the community by the agency. Thus, the agency is about to cover 85 to 90% of the population in its each annual survey for leprosy detection. This shows the community's awareness towards the importance of early detection and also the efficiency of the agency's staff. Active case detection through surveys has now been discontinued and health education intensified

to encourage voluntary reporting. 60% of the total cases are through voluntary reporting.

The methodology employed by the GMLF to remove social stigma and rehabilitation of leprosy patients is in keeping with their health education work. The patients are not kept in colonies, nor are they isolated from society in any other way. They are advised to stay in their homes and take treatment from the OPD. The GMLF have not found any instances of social displacement of leprosy patients in their area. They also give guidance to the leprosy patients to solve their social and other problems.

**Activities and Achievements :**

The project was started with a survey of the area to detect leprosy cases. This survey covered 93% of population and detected 374 cases of leprosy. Thereafter in 1952 the first Leprosy Control Unit was started in Sevagram. This unit undertook survey, education and treatment of leprosy in that area. In 1965, with the establishment of a Leprosy Referral Hospital at Wardha, they could provide much more efficient and expert services to the patients and carry out research work.

The project has documented its work very well. The research input, both clinical and sociological, is very significant. They maintain records :

a) of individual patients living in the area;
b) of patients under treatment; and
c) of the entire population in the area.

In addition, the agency has been undertaking training programmes since 1951. They have three training centres in three states of India. Courses offered are as follows :

1. Matriculates sponsored by voluntary agencies or state or central government;
2. Two months course in health education for trained and experienced leprosy workers;
3. Six weeks course for medical officers;
4. One month course in laboratory techniques; and
5. Other short orientation courses for motivated college students (NSS, NCC), development workers and teachers.

The Health Education Unit of the agency (established in 1961) in addition to providing training as mentioned above, organised 99 meetings in 1981-82 of teachers, office workers, housewives, students, associations and others. About 4,534 persons participated in these meetings. Public meetings and exhibitions on leprosy have also been organised. The GMLF maintains close liaison with nearly 60 voluntary organisations. The Foundation is presently in the process of setting up a social science research centre for leprosy.

**Finances :**

The total expenditure of GMLF for the year 1983-84 was Rs.1.91 million. Of this amount 42% was spent on the 5 LCUs, 7% for hospital, 50% for the training centre in Wardha, 4% for health education units and the remaining for other activities.

The total income for the year 1983-84 was Rs.1.84 million out of which 0.67 lakhs (3.6%) were received as grant from the government, Rs.9.24 lakhs (50.1%) from other Indian sources, Rs.3.8

lakhs (20.6%) from international sources and Rs.4.74 lakhs (25.7%) was from the GMLF's own sources.

## 38. KASTURBA RURAL HEALTH SERVICES PROJECT

**Name and Address of Project** : Kasturba Rural Health Service Project,
C/o Kasturba Sarvodaya Mandal,
Madhan,
Dist: Amravati

**Project-in-Charge** : Smt. Vatsalabai Kale

The Kasturba Rural Health Service Project was started in March 1977. The Kasturba Sarvodaya Mandal had been functioning in Madhan since 1946. The main focus of the project is on maternal and child health and this activity is sponsored largely by OXFAM. A base-line survey was undertaken before initiating the project.

**Aims and Objectives :**

The present health system is inadequate and is biased in favour of the urban population. It is therefore necessary to initiate and conduct community health projects in the rural areas. Child welfare, MCH, education, general health and social service are the overall objectives of the project.

**Social Geography :**

The Kasturba Rural Health Service Project covers nine villages and a population of 15,560. The inhabitants of the project area are mainly tribals. Khatladki, the subcentre of the project is at a distance of 16 kms. from Madhan and is located at the foothills of the Satpuda range in the interiors. About half of the villages have state transport (bus) facilities and 75% of the villages are electrified. The current birth rate is 15.4 per 1000 population and the death rate is 5 per 1000. The IMR for the project area is 53 per thousand live births (information supplied by the project). There are very few private practitioners in the project area which is hilly and backward. The project villages are also drought prone and impoverished. As stated by the project, the project area is low endemic for both TB and leprosy (less than 5 per 1000 population).

**Organisation and Methodology :**

The project has one honorary doctor, three nurse-midwives, 12 CHWs, two community organisers and a clerk for administrative purposes. The honorary doctor visits the project once in two months. During the meetings with the staff various issues such as medication, harm due to overmedication, survey of patients, detection of diseases such as filaria, and indigenous methods of treatment of disease are discussed. Non-health issues such as gobar gas and the like are also taken up during these meetings.

Weekly clinics are held in all the project villages. At Khatladki is the subcentre of the project. Home visits are undertaken to encourage child immunisations. The CHW reports to the ANM twice a week. Immunisations are given at the PHC in Talvel. Ante-natal immunisation and the triple antigen doses are provided by OXFAM. Development of children is monitored through growth charts. Wherever possible, the cooperation of gram panchayats is sought.

**Activities and Achievements :**

Regular MCH (ANC, PNC and under-five) clinics are organised at Madhan and Khatladki. Through these clinics, enumeration of all pregnant women and of children is undertaken so that their health can be monitored. Family planning advice is given. Eligible couples are sent to the PHCs at Talvel or Amravati.

Nutrition education is imparted through charts. However, the project personnel feel that poverty and ignorance prevent the people from providing good nutrition to children and mothers. Women labourers do not have enough time to follow up the required immunisations or to take enough care of their children.

The monthly leprosy clinics (SET) are organised along with the Kothara Mission. However, the problem that the project encounters is the reluctance of the people to admit the fact that they have leprosy. The project has maintained good relations with the neighbouring PHCs and with all the gram panchayats of their villages. Through such cooperative efforts regular disinfection of wells as well as nutrition education is undertaken.

The project has been able to considerably decrease the birth, death and IMR rates in their area.

Home visits have to be undertaken to persuade women to continue immunisations. Group meetings are not possible because women go out to work.

At present the project is planning to undertake a supplementary nutrition programme (Sukdi) with the assistance of OXFAM to combat gross malnourishment due to drought. The project is also planning to send a batch of women to some voluntary organisation for CHW and ANM training as well as for enhanced job experience.

**Finances :**

The project is funded half and half through OXFAM and state government grants. The total income for the year 1983-84 was Rs.52,500. Out of this, Rs.33,780 were spent on salaries; Rs.9,000 on medicines and the rest on maintenance, travel and so on.

## 39.* LOK BIRADARI PRAKALP

**Name and Address of Project** : Lok Biradari Prakalp
At: Hemalkasa
P.O. Bhamragarh
Gadchiroli

**Project-in-Charge** : Dr. Prakash Amte

Lok Biradari Prakalp is the latest project of the Maharogi Sewa Samiti, Warora, whose first project is situated at Anandwan near Warora in Chandrapur District. In 1973 Baba Amte set up a hut dispensary in this area. He stayed there for a while and got the project going. Later his son, Dr. Prakash Amte accepted the responsibility of taking care of the project. The area did not have any health facilities whatsoever. It was, and to some extent still is, completely isolated. With the exception of the forest department no governmental or non-governmental agency is active in this region.

**Aims and Objectives :**

The stated objectives are :

1. To provide basic health facilities
2. To promote education and to make people conscious of their rights.
3. To undertake agricultural extension programmes.

**Social Geography :**

In the first year of operation, the project covered 20 villages with a total population of 5,000. The first action programme was, as mentioned earlier, the setting up of a dispensary. This provided an entry-point to expand into other fields of activities. Within 12 years of its existence the project has expaned to cover 150 villages and hamlets, with a total population of 20,000.

The people of this area are predominantly tribals - 95% of them being Madia Gonds. The area is a reserved forest with an insignificant market economy. The access road is Kuccha; only one State Transport bus operates daily for 6 months in a year. For six months, during and a little after the monsoons, it is nearly impossible to visit the area. Most of the villages do not have electricity, nor any facility for telecommunication.

The tribals are mainly animists believing in the 'mother goddess'. They speak the Madia language which has no written script.

The people in the project villages depended for water, until recently, on rivers and open wells. Such water has a high content of iron and organic matter. Recently, due to the Prakalp's intervention some of the project villages have been provided with borewells in the ratio of one borewell to 200 population. The main crop in the region is paddy.

Epidemiologically, this area is highly endemic to malaria. The incidence of cerebral malaria is also high. In 1974 the agency hospital treated 93 cases of cerebral malaria; in 1980, 68 cases; in 1981, 69 cases; and in 1982, 35 cases. Apart from malaria other causes of morbidity are injuries, bites, malnutrition, tuberculosis, leprosy, yaws and gastro-enteritis. Mortality is very high in cerebral malaria cases. Diarrhoea in children is also a major killer in this area.

The census (1981) data for Sironcha tehsil shows that 64% of the population belong to the scheduled tribes and scheduled castes. The scheduled tribes alone constitute 53% of the total population. The literacy rate is very low, being only 17%. Literacy among women is abysmally low, being only 9% of the total female population, as compared to 25% literacy among males. 45% of the population is categorised by the census as being workers, and of these workers 61% are cultivators while 19% are agricultural labourers. The process of urbanisation has not taken place at all in this tehsil and the market economy is negligible.

**Organisation and Methodology :**

In the first year of its operation, the project had four volunteers. Seven more persons were added in the course of the next ten years. The community health services were started in June 1978. Village level volunteers to do community health work were selected from three categories of persons.

Out of the 12 persons trained to work at village level in the first year of community health project, 4 were tribal youths who studied in the Ashram school and showed interest in health work; 2 were outside volunteers and 6 were cured leprosy patients. At present the project has a total of 15 persons working at the village level.

These village level workers work at 8 centres set up by the Prakalp inside the forest in different villages. Each of these sub-centres is provided with medicines and other necesssities by the Prakalp. These village level workers normally do not visit households. They also look after public health work in the centre villages as well as in the villages nearby. They are paid Rs.200/- per month and the medical services are provided free.

The methodology used by the Prakalp for initiating change among the tribals is that of education and practical demonstration in various fields like agriculture and education. Children learn various methods of agriculture and experiment with them in their own villages during the vacation. When they finish their schooling and decide to settle in their own villages, they follow the methods taught to them. Thus, the Prakalp aims at a gradual but much more deep-rooted change in the people's perception and practices. The health work is one component of that methodology.

**Activities and Achievements :**

The village level workers of the project perform both health and non-health work.

1. They cure all minor ailments.
2. They conduct vaccination programmes.
3. They carry out agricultural extension programmes.
4. They act as one of the members of the village panch committee.

In addition to the hospital the Prakalp runs an Ashram school providing formal and non-formal education. It was started in 1976, with 26 students. In 1983, there were 261 tribal students, 36 of them girls. The school provides education upto the 7th standard. The non-formal aspect of this education includes training in proper agricultural methods, making the tribals conscious about their rights so as to fight against corruption and exploitation. Some of them are also trained to become village-level workers.

The agriculture extension programme was the first non-health programme. It was started in 1974. The villagers were given demonstrations in agricultural methods in different villages by the health workers. The Prakalp also provides high yielding variety seeds of paddy as well as vegetable seeds.

Besides these activities the Prakalp also runs an orphanage with 12 tribal children and a zoo with many animals and birds.

Despite Baba Amte's prestige and the Prakalp's own achievements in the last decade, the project faces problems from the government. The agency's Ashram school is the best run in the region and has consistently produced the best results and yet it is still not recognised by the government and hence not eligible to receive regular grant-in-aid from the government. Ironically during the winter session of the Maharashtra Assembly in Nagpur, ministers and MLAs regularly visit the project to see the zoo and other institutions. About five years ago the government established a PHC in Bhamragarh,

just three kms from the Prakalp hospital despite being aware of the fact that a well-equipped hospital has been functioning efficiently in Hemalkasa.

The Lok Biradari Prakalp, led by Baba Amte, is also spearheading an agitation against building a huge dam in the adjacent Bhopalpatnam area which will submerge most of the project area and also a vast area of the forest rendering tens of thousands of tribals homeless.

**Finances :**

The annual expenditure of the Prakalp for its various activities amounts to about 4.5 lakhs. So far OXFAM provided Rs.2,42,000/- annually. Action Aid supplies funds for the maintenance of 130 children in the Ashram school. The rest is obtained from donations. The Somnath Project of the Maharogi Sewa Samiti, Warora, provides part of the necessities like grain, vegetables and seeds.

Swiss Aid, another funding agency, has funded capital expenditure. The Prakalp has spent about Rs.11,000/- in setting up each sub-centre manned by a village health worker.

## 40.* MAHAROGI SEVA SAMITI, WARDHA

**Name and Address of Project** : Maharogi Seva Samiti,
Manohar Arogya Niketan,
Dattapur, Wardha.

**Project-in-Charge** : Dr. R.P. Jyotishi, Director

The project was established as early as 1936 when Manohar Diwan, a close associate of Gandhi, affected by the plight of leprosy patients, decided to shelter, treat and rehabilitate them. The objective at that point was to check the spread of leprosy to the general population; therefore leprosy patients had to be necessarily confined as there was no cure available for the treatment of leprosy. Presently the project is undergoing basic changes in its approach to the problem, mainly due to the influence to GMLF (See profile of GMLF).

**Aims and Objectives :**

The aim of the project is to make constant efforts to give shelter to patients rejected in society by developing a spirit of self confidence and by traning them in some productive work so as to enable them to earn their living. The Samiti is also actively engaged in the development of neighbouring villages on Sarvodaya lines as envisaged by Gandhi. In fact the late Vinoba Bhave wished that the Dattapur unit function as an extension to the Brahma Vidya Mandir, his own ashram at Paunar, Wardha.

**Social Geography :**

Wardha district in the Vidarbha region of Maharashtra, is a high endemic area for leprosy. The area also has a large number of Gandhian institutions. For a description of Wardha Tehsil see profile of GMLF.

**Organisation and Methodology :**

The Maharogi Seva Samiti has five units :

1. The medical unit (150 bedded hospital with four male and three female wards);
2. The vocational centre;
3. Shelter work-shop;
4. Infirmary for deformed and terminal cases; and
5. The children's wing with accommodation for 150 healthy children of leprosy patients.

The Samiti asylum has a maximum capacity of 800 patients. Each year approximately one fourth of the inmates (about 200 to 250) are discharged.

The medical centre has a colony OPD, a general OPD as well as a skin disease and leprosy OPD for the community around Dattapur area. Besides the OPDs there are the indoor medical wards. There is also a clinical pathology laboratory.

The Dattapur colony has been working with the philosophy that colonisation of leprosy patients even today is vital. Their methodology is based on the following principles :

1. A large percentage of infectious type of cases develop complications for which they require to be hospitalised.
2. A large number of cases, because of deformity and social boycott, require shelter and work and training in handicrafts for their rehabilitation because leprosy patients on reaching colonies are found to be extremely difident about their working capacity. Their morale has to be built up so that when they leave the colony they can function with confidence.
3. The mutilated persons, the blind and the crippled, although cured of leprosy, badly require a shelter because either these persons are destitute or are not welcome in their homes due to fear of leprosy. Such cases need permanent shelter in an 'infirmary'.
4. The working leprosy patient, although he has a home, does not find work because of social boycott. He needs a shelter work-shop where he can earn his bread.

Dattapur carries on its leprosy work with the help of two medical officers, three medical assistants, three non-medical assistants, two leprosy technicians, one laboratory technician, two physio-therapists, one compounder, one ANM, two nursing assistants and about 20 auxillary nursing staff, both male and female selected out of the patients.

**Activities and Achievements :**

In addition to the hospital and the OPD, the Samiti implements the SET programme in the neighbouring villages covering a population of 50,000. The multi-drug regimen is also followed.

Besides health activities, the Maharogi Seva Samiti have their own 250 acre farm as well as a dairy where cross-bred cows are reared for enhanced milk production. These units alongwith the rehabilitation centre and the shelter work-shops have made the institution self sufficient in terms of food, clothes and shelter. The Samiti also conducts various training courses for all categories of leprosy patients.

The institution is insured for health purposes with the Kasturba Health Society and Sevagram Medical College whereby the patients in the Dattapur today get the advantage of the specialists' examination as well as treatment in the different departments of the Medical College.

In Dattapur there is a full fledged khadi industries section where the patients earn their livelihood partly by spinning on the Ambar Charkha as well as in the other production units of the khadi section.

In the children's wing there is one hostel for healthy children of leprosy patients and three hostels for leprosy affected children. The Samiti also has a school and library for these children. In their extension programme, the Samiti has started balwadis and a school for agricultural and non-agricultural workers' children.

The project personnel also hold discussions and prayer meetings of the inmates to instill into them spiritual awareness. This spiritual teaching is carried even into the project villages along with their other development work.

The Board of Management has reconsidered the entire working of the Samiti in view of the new thinking and experience of the first two decades leprosy control work in the country. As a consequence, they have decided to change the shape of the institution from one of providing a long-term asylum to one of a modern hospital. It is now restricting its admissions to those who need short-term medical attention and to encouraging and assisting those who had made it a home. As admissions to child-patients are available in most of the schools, the special school will be closed from next year. Similarly it will not continue the hostel for healthy children because this results in attaching the social stigma to them without their having the disease and creates a psychological trauma in these children due to their living in a colony of leprosy patients. Finally, instead of discharging patients from the institution without any follow-up, efforts will be made for every discharged patient to see that they are accepted by society and their family.

**Finances :**

Funds are received from individual sympathisers as well as funding agencies. In 1982-83, Rs.94,000/- was collected through individual donations. The KVIC support the khadi section. LEPRA, the British Leprosy Relief Association for children's treatment aids the children's wing of the project. Funds amounting to a lakh of rupees are received from the Terre Des Hommes (Germany). Grant-in-aid in the form of recurring grants are received from the DHO and ZP, Wardha, the Divisional Social Welfare Officer, Nagpur, as well as the Central Social Welfare Board, New Delhi. The total budget for the year 1982-83 was Rs.11,41,105.35.

## 41.* MURE MEMORIAL HOSPITAL (MMH)

**Name and Address of Project** : Mure Memorial Hospital,
Nagpur,
Field Project at Shivangaon,
Nagpur.

**Project-in-Charge** : Dr. S.P. Mukherjee,
Director, MMH

This health and development project was started by the Mure Memorial Hospital in 1975.

**Aims and Objectives :**

Earlier, mobile health clinics were run by the Christian Medical College with a charitable

missionary spirit but the present objective of the MMH is to avoid giving any services free to the people. The emphasis has changed 'to educate and train' rather than 'to serve'. The trainees in-turn are encouraged to train other people. Health education is given more importance as compared to curative or preventive services. As doctors tend to be more inclined towards cure of illness, the MMH has always discouraged doctors from associating with the communithy health programmes; instead social workers are encouraged for their holistic approach towards health and development.

**Social Geography :**

The field project is located at Shivangaon which is about 25 kms. away from Nagpur city. Twenty five villages are covered by the project and during the rains only ten villages are accessible.

The area covered by them is mostly part of Nagpur tehsil which has a sex ratio of 915 females per 1000 males and a literacy rate of 44%. The average household size is of 4.9 persons and non-workers constitute 52% of the population.

The area is politically active with the militant Hindu organisation, the RSS, being very strong. Political conflict between the MMH and the RSS occurs frequently as the latter feel that MMH infiltrated the villages for proselytisation.

**Organisation and Methodology :**

The Mure Memorial Hospital is a sophisticated medical institution that is being further modernised. In Shivangaon there is a clinic cum training centre. The full time clinic has curative, immunisation and FP advice facilities. Though there are two beds for deliveries, usually home deliveries are encouraged. Trainee nurses (ANMs) from neighbouring voluntary agencies such as the Matru Seva Sangh use the Shivangaon centre for their field study (one month during the second year of training).

The methodology and approach of the MMH has changed dramatically since the days of the charity oriented mobile health clinics. The earlier focus of the community programme was oriented towards family planning. For three years the MMH worked in one village. An evaluation by a German team however brought out that employment should be the first priority in a community project and within health - FP should be the last.

As a consequence the project began organising women into Mahila Mandals who identified felt needs and this helped MMH to chalk out programmes. Thus sewing classes were started and local women trained to look after their own community.

MMH also realised that doctors were a bane to people's health - the more specialised the more irrelevant he or she becomes. This was brought out by the experience that while doctors or post-graduate social workers proved ineffective, a village youth with not much formal training could adapt himself to all the needs of the community - being a driver, mechanic, social worker and radiology technician. Ever since then, the MMH encouraged local motivated persons rather than qualified personnel from outside. The need for a doctor to be stationed at the Shivangaon centre has been gradually reduced. For the past six years the centre has been largely managed by ANMs, dais and other local persons.

**Activities and Achievements :**

MMH nurses are trained at the Shivangaon centre. The Matru Seva Sangh ANMs and MPHW

trainees also use Shivangaon for their field experience. Students are imparted training according to their syllabus - mainly MCH. Otherwise the project's own programme is taught. Home remedies such as application of neem juice with turmeric and oil for scabies and treatment of hookworm with papaya seeds is encouraged. When problems have been identified at Mahila Mandal group meetings, the required discussions are held. Demonstrations on health issues are arranged at such meetings. Mahila Mandals are registered with the government. Problems related to wife beating, alcoholism and casteism are taken up.

For ten years the project managed the sewing classes and nursery school in Shivangaon. Now the Mahila Mandal has taken over both the programmes. The project tries not to take up the responsibility of starting economic ventures but encourage the women to do so on their own. The MMH staff only offer consultations.

The trainee ANMs of MMH conduct a family survey and aquaint themselves with rural problems. The MPHW for a month register women for ANC and PNC services and pre-schoolers for immunisation. Village health guides are taught preventive care and home remedies. With the help of flash cards, demonstrations and posters school health teaching is conducted on common problems like worms, head lice, diarrhoea or contagious diseases. FP advice and contraceptive distribution is carried on at the clinic in Shivangaon. Since Cu-T has a high rejection rate due to infection and painful side effects, women prefer to take pills. Condoms create disposal problems, according to the village women. More women than men are ready for sterilisation because the failure rate after vasectomy has been discouraging.

**Finances :**

The Dutch donor agency (ICCO), connected with the national church, funds the Mure Memorial Hospital through the Dutch government. The ICCO funds are mainly utilised for health, especially ANC-PNC, programmes. It has also been used to build the infrastructure of the Shivangaon project. The day care centre and sewing classes are supported by German 'Friends of Mure'. These friends also support an agricultural farm whose produce goes to the community health project. The amount of funding received either from the ICCO or 'Friends of Mure' has not been made available. Also details of expenditure were not provided.

## 42.* VANITA SAMAJ, AMRAVATI

**Name and Address of Project** : Vanita Samaj, Amravati
Dist: Amravati.

**Project-in-Charge** : Smt. Leelatai Bhat
(as per annual report 1978-79)

This is one of the oldest institutions for women in the Vidarbha region, being established as early as 1893. The project started a school in 1939 and it received government recognition in 1942.

The project has numerous activities including schools, balwadis and training programmes. Though the project does not have a health component they train women to become Aanganwadi and health workers.

**Aims and Objectives :**

To make women, especially of the lower socio-economic class economically independent by training them in vocational and teaching skills. The main objective of the project is the overall development of women and children.

**Social Geography :**

The project functions in Amravati town. They have no outreach programme into the surrounding villages. Amravati district is in the Vidarbha region of Maharashtra and has many voluntary agencies especially those adhering to the Gandhian Sarvodaya philosophy.

**Organisation and Methodology :**

The project has a general body membership of 180. They have an executive committee and an advisory board, all consisting of women. Vanita Samaj has three primary schools, two preschool kindergartens as well as a typing class and sewing classes where they conduct certificate course examinations. The project also has a library and a family welfare centre. Care is taken to see that the teacher-parent relationship is maintained in the schools through the teacher-parent association. Parents are invited to quarterly meetings by this association to discuss the progress of their children.

**Activities and Achievements :**

Besides conducting the above mentioned schools the project has many extra-curricular activities for children and women. Games are encouraged through open badminton courts which are open to all. Women of the local community also gather for meetings, discussions and cultural programmes such as "haldi-kumkums". The Indian Council for Child Welfare, New Delhi, has recognised the Vanita Samaj as the official training centre for ICDS and Aanganwadi Workers. It is the only recognised institution in the Vidarbha region. Women trained in this institute have been absorbed as pre-primary teachers, community volunteers, assistant health visitors, female attendants, creche workers, child caretakers as well as Balwadi and Aaganwadi teachers in Amravati district under the auspices of the ICDS. Training programmes for women have been conducted since 1963. More than 85% of the trained women on an average get jobs each year according to the Vanita Samaj report.

Trainees come mostly from rural areas and 30% seats are reserved for SC and ST. Trainees receive a stipend of Rs.75/- per month during their 11 months training period.

In 1980 Vanita Samaj built a hostel for women trainees. Hostel expenses are subsidised by Vanita Samaj.

Women trainees are sent to various camps and conferences such as the All India Village Health Worker's meet and ICCW meetings to increase their self confidence and exposure.

The Vanita Samaj works in close co-operation with other voluntary organisations in Amravati town and neighbouring talukas. They also seek the co-operation of the local Lion's clubs as well as philanthropic and motivated individuals.

**Finances :**

No information was made available regarding budgeting, expenditure or source of funds.

## 43.* VIDARBHA MAHAROGI SEVA MANDAL

**Name and Address of Project** : Vidarbha Maharogi Seva Mandal,
Shri Jagdamba Kushtha Nivas,
Tapovan, Amravati.

**Project-in-Charge** : Mrs. Anootai Bhagwat

This institution is a treatment and shelter home for leprosy patients. Its founders were inspired and encouraged by Mahatma Gandhi. The Jagdamba Kushtha Nivas was established in 1950. The actual work had been, however, started four years earlier in 1946. This leprosy home was established to provide the leprosy patients with an alternative to the foreign missionary institutions. (This project was terminated in 1984 after a confrontation with the government by it's 91 year old founder, Dr. Shivajirao Patwardhan.

**Aims and Objectives :**

The stated objectives are :

1. To combat leprosy by providing treatment, rehabilitation, and psychological and social assistance to leprosy patients;
2. To restore human status to leprosy patients who had lost it on account of the stigmatising disease;
3. To bring out human dignity in full measure in the patient who for no fault of his and merely on account of sickness was dehumanised by society;
4. Rural development in the project area; and
5. Research in leprosy, particularly on the psychological aspects of the disease and its cure.

**Social Geography :**

Vidarbha region of Maharashtra, alongwith Marathwada region show a higher endemicity in leprosy as compared to other regions. Wardha, Chandrapur and Gadchiroli districts have prevalence rates of leprosy more than 10 per 1000 population while Yavatmal, Amravati, Nagpur and Bhandara have prevalence rates between 5 to 10 per 1000 population. This agency is not confined to Amravati district. It has centres in Yavatmal and Akola districts too. The total number of such centres is seven and the total population covered is around two lakhs.

**Organisation and Methodology :**

The institution houses 1400 inmates in its seven centres. It has a total staff of 155 persons. The staff includes four agricultural assistants, 16 nurses, 5 honorary doctors, 2 full-time doctors, one medical social worker, 2 physiotherapists and others like cooks, teachers to teach in the school as well as to teach various crafts, administrative staff, drivers and so on.

This institution is meant basically to be run by patients themselves but with initial help by non-patients in training them to do so. There is an executive committee of 15 members out of which 7 live in Tapovan; four of them are ex-patients, including the secretary and deputy secretary. The other 8 members are in Amravati town including ex-officio members, the collector and district health officer.

One member is a competent physician and another an eminent surgeon. The general body of the institution consists of 150 ordinary members.

The methodology of work consists of "work-therapy" along with treatment of leprosy. Patients are hospitalised if needed, otherwise while under treatment for ulcers and reactions, they go on getting training and/or work. They are thus helped to become self-reliant human beings. Cured patients can go home but those requiring long treatment can depend on immediate hospitalisation and yet remain self-reliant, earning their own living.

**Activities and Achievements :**

The Mandal offers institutional services to leprosy patients. The facilities available include those for treatment, hospitalisation and rehabilitation. Arrangements have also been made to accomodate 250 patients' families for their settlement within the Mandal's campus. They work in the Mandal's industries and their children can go to the two primary schools and a high school run by the Mandal. The Mandal also has two orphanages and a hostel for healthy children of leprosy patients. Old, destitute leprosy patients are kept in an infirmary.

The agency has registered some achievements after more than three decades of pioneering work. They feel that there is a definite dent in the stigma and attitude of people in Amravati town. This is reflected in the acceptance of the Mandal's products such as bandage, guaze, bedsheets, furniture, furniture, books, stationery, eggs, chickens and so on by the government hospitals and others.

The major problem the institution faces is in getting new personnel who have the motivation and devotion to serve patients.

**Finances :**

The annual budget of the Mandal exceeds Rs.34 lakhs. Of Rs.34,39,104 spent by it in the year 1981-82, the agency received 48% from the government as grant-in-aid, while 41% came from the sale of agricultural and industrial products. Only 6% of their income came through donations. Details about expenditure were not made available.

## 44.* VIDHARBHA VANVASI KALYAN ASHRAM, NAGPUR

**Name and Address of Project** : Vidharbha Vanvasi Kalyan Ashram,
199, Shankar Nagar,
Nagpur 440 010
(Project in Yavatmal District)

**Project-in-Charge** : Secretary

The project located in Yeotmal district has been operating since 1978. It runs three dispensaries in three different talukas of Yeotmal covering mainly tribal populations.

**Aims and Objectives :**

The main objective of this project is to take medical care to the tribals in close proximity to their place of residence, especially in areas not covered by government PHCs and dispensaries.

**Social Geography :**

Yeotmal in the Vidharbha region, is a very backward area having a tribal population of 21%. The average household size in this district is 5.2 persons (4.9 for tribals) and the sex ratio is 958 females per 1000 males. The literacy rate is 39.3% (26.9% for females) but among the tribals it is 24.3% (12.9% for females). The non-working population constitutes 51% of the total population (42% amongst tribals) and out of the work-force 53.5% are agricultural labourers (66.4% amongst tribals) - of these agricultural labourers 53% are women.

**Organisation and Methodology :**

The project runs three dispensaries, one daily and the other two bi-weekly, with the assistance of a private medical practitioner (an RMP) and occasionally a doctor couple from Nagpur. They are assisted by an organiser and a trained dai. The project does not envisage any community health work in the near future.

**Activities and Achievements :**

The project has regular clinics in three different talukas serving a tribal population of 27 villages around the three centres. Services and medicines are provided free of cost. Also, occasionally diagnostic camps and immunisation camps have been organised. No further details of activities were available.

**Finance :**

In 1981 the project spent Rs.9,595/- on their medical care programme. No other details were available.

## 45.* SWAMI VIVEKANAND MEDICAL MISSION CENTRE, NAGPUR

**Name and Address of Project** : Swami Vivekanand Medical Mission Centre, Khapri, Dist: Nagpur.

**Project-in-Charge** :

The project was started at Khapri on second October 1982 and is affiliated to the Royal Commonwealth Society for the Blind. This project deals with problems exclusive to xeropthalmia.

**Aims and Objectives :**

The project aims at a complete population enumeration, listing pregnant and lactating women as well as children under five years, medical examination to identify cases with xeropthalmia and determining "at risk" children for future follow-up.

**Social Geography :**

The villages in the project area are small with an average population of 400 to 500. The gram panchayat covers a population of 800 to 1200, covering 2 to 3 villages. Each 'module' of the project covers 5 gram panchayats on an average. Villages are separated from each other by an average distance of 3-4 kms, many of them being inaccessible during the monsoons.

The villages on the outskirts of Nagpur city have a marked migratory character, the mobility being influenced by rapid industrial expansion. A survey conducted by this project indicates that about 40% families have moderate landholding and the remainder are mainly dependent on agricultural labour.

**Organisation and Methodology :**

The project has adopted the 'module pattern' through which a population of about 5,000 is enumerated; pregnant, and lactating women as well as children under the age of five years identified; and screening of the population for xeropthalmia is conducted by the Community Health Volunteers trained by the agency. A listing of totally blind persons and of those showing signs of contract is made so that the latter cases can be referred to the hospital for treatment. The project functions through the PHC staff for immunisation of children and prophylaxis of xeropthalmia through vitamin A concentrate.

**Activities and Achievements :**

Until now the project has completed 4 modules (each lasting 12 weeks). A total population of 21,175 has been enumerated. Of the 2,739 under-five children medically examined, 517 (19%) were identified as "at risk" for xeropthalmia. 18% children were grade III malnourished. Cases with conjunctival xerosis were identified and Betot spots were used as a criterion for identifying xeropthalmia. 1,483 children identified as "at risk" were given vitamin A concentrate (2 lakh units). The children have been followed up by preparing "road to health" charts. Nutritional levels were enhanced by feeding programmes and by encouraging the villagers to grow vegetables in kitchen gardens.

With the assistance of the PHC staff the project has carried out immunisation of infants enumerated during their population survey. Health education has been imparted through mahila mandal meetings. Wall painting and posters have been used to propagate messages.

The project has encouraged nutrition oriented social forestry. During the wet season they have planted vitamin A rich plants and trees in kitchen gardens in most of their villages. Vacant grounds belonging to the Gram Panchayat have also been utilised, according to the project personnel. In all, 36 villages have been covered. All the project CHWs and supervisors provide information and demonstration for such plantations. Plants and seeds are provided by the project nursery.

Xeropthalmia prevalence has declined markedly in the project area. In September 1983 (after the completion of four modules) there were 34 cases of Betot spots bringing down the prevalence to 1.2%.

During their work through the 'module approach' the project staff have noticed a seasonal variation of xeropthalmina, the worst season being summer when food consumption is lowest due to shortage. Exclusive breast feeding for too long has also accelarated xeropthalmina. Also in some villages, xeropthalmina cases did not show Betot spots. With these observations, the mission personnel have raised important issues : Should villages be kept under constant surveillance in view of the existence of grade III malnourishment ? Should the feeding programme continue ? And lastly, what could be the criteria for pulling out from the villages in the light of the fact that economic, social and cultural conditions which cause xeropthalmina are constantly prevalent in the villages ?

**Finances :**

The Royal Commonwealth Society for the Blind funds the project. Details about budgeting and expenditure have not been made available.

## PART - V : APPENDICES

In this concluding part of the report, besides the questionnaire and the bibliography, we have included information that does not have any direct relevance to the study but is nonetheless important.

In Appendix 'A' we have presented a financial analysis of selected 'voluntary' hospitals (allopathic) located in Bombay city to indicate the pattern of investment in the health sector. Appendix 'B' contains selected health services data for the State of Maharashtra which we have compiled from various sources.

Addresses of NGOs who we had identified but could not include in the study, because either the information available/provided was insufficient or the NGOs did not respond or worse still the postal department returned the communications sent to some of them marking "addressee not existing", have been listed in Appendix 'C'. The questionnaire used for data collection forms the Appendix 'D' and the bibliography Appendix 'E'.

## APPENDIX 'A'

### A Note on Public Trust and Selected 'Voluntary' Hospitals in Bombay

Published data on the finances and activities of public trusts and societies registered under the Bombay Public Trusts Act 1950 is available only for the year 1976.

In Greater Bombay District alone in 1976 there were 15,932 trusts and societies out of which 12.6% are medical establishments. For Maharashtra State in the same year the figure was a staggering 71,733 trusts and 15,264 societies.

The table below gives some important information about such trusts and societies located in Bombay.

**Financial Information on Trusts in Bombay - 1976**

(Rs. Lakhs)

| Type of Trusts | Total Number | Total Assets | Income | Expenditure |
|---|---|---|---|---|
| Hindu | 2954 (195) | 6449.27 | 939.09 | 875.51 |
| Muslim | 1207 (112) | 2008.93 | 319.20 | 446.96 |
| Parsi | 1001 (68) | 3516.45 | 380.79 | 342.48 |
| Christian, Jew, etc. | 238 (12) | 1411.58 | 262.60 | 190.71 |
| Cosmopolitan | 6250 (1432) | 13635.16 | 3562.91 | 3389.83 |
| Societies | 4282 | 12331.86 | 3990.95 | 551.84 |
| TOTAL | 15932 (2010) | 39353.25 | 9455.54 | 5797.33 |

(Figures in parentheses are the number of medical establishments)

**Source :** Compiled from Director of Public Trusts - Greater Bombay, Bombay Suburban Districts, Government of Maharashtra, Bombay : Volume I 1979, Volume II 1980, Volume III 1981.

It must be noted that these trusts and societies range from small mandals to large institutions or from street corner citizens' groups to large corporate house trusts.

We visited the charity commissioner's office to get an update on information but it was not available in a compiled form. However the charity commissioner gave us permission to go through records of selected 'voluntary' hospitals.

We could not get information on these selected hospitals for a single year because many institutions do not file their returns regularly or systematically, including some of the city's largest and expensive hospitals.

The data compiled by us in the following table gives information for 44 hospitals of Bombay City ranging from assets of Rs.0.35 lakhs to Rs.1100.75 lakhs (Mean=Rs.110.8 lakhs). The information compiled by us is based on single-year returns of the trusts (all cosmopolitan), the years varying between 1980 and 1984 (Mean year=1983). This is compared with information for 1976 which was available for 40 of the 44 hospitals.

**Financial Information on Selected 'Voluntary' Hospitals of Bombay (1976 and 1983)**

(Rs. lakhs)

| Year | Total Assets | Income | | | Expenditure | | |
|---|---|---|---|---|---|---|---|
| | | Donation & Grants | Other Sources | Total | Medical Relief | Other | Total |
| 1976 | 1862.53 | -- | -- | 499.46 | -- | -- | 479.68 |
| Mean year 1983 | 4985.87 | 130.11 | 2025.83 | 2155.94 | 1002.41 | 1322.76 | 2325.17 |

The above table indicates that assets have increased by Rs.3123.84 lakhs or 168%, income by Rs.1656.48 lakhs or 332% and expenditure by Rs.1845.49 lakhs or 385% between the two periods, which one may take as seven years because the mean year works out to 1983.

To this may be added the fact that the three large hospitals (Jaslok Hospital, Bombay Hospital and Breach Candy Hospital) were responsible for a staggering 76% of the increase in assets, 79% of the increase in income and 84% of the increase in expenditure. (It may be noted here that the 4 hospitals for which 1976 data is not available together account for only 0.8% of the assets, 0.2% of income and 0.2% of expenditure from among all the 44 hospitals).

This data is then a clear pointer towards the pattern of investment in health care, the class of population that is served by the best hospitals and the nature of the NGO sector in health and medicine.

## APPENDIX 'B'

### Population Characteristics and Health Care Services in Maharashtra

### Selected Information

**I. Socio-Economic Data**

| | | | |
|---|---|---|---|
| 1. | Urban Population (percent, 1981) | .. | 35.03 |
| 2. | Average Household Size (persons, 1981) | .. | 5.37 |
| 3. | Literates in Population (percent, 1981) | .. | 47.18 |
| 4. | Sex Ratio (Females/1000 Males, 1981) | .. | 937.00 |
| 5. | Scheduled Castes in Population (percent 1981) | .. | 7.14 |
| 6. | Scheduled Tribes in Population (percent, 1981) | .. | 9.19 |
| 7. | CMIE Index score (1980) | .. | 163.00 |
| 8. | Main Workers in Population (percent, 1981) | .. | 38.71 |
| 9. | Agricultural workers as percent of Main Workers (percent, 1981) | | 26.63 |
| 10. | Ratio of Agricultural Labourer to Cultivator (percent, 1981) | .. | 75.81 |
| 11. | Main Workers in Non-agricultural sector (percent, 1981) | .. | 38.25 |
| 12. | Average Size of Operational Holding (hectares, 1976-77) | .. | 3.66 |
| 13. | Percapita Production of Food Grains (Kgs., avg. of 1975-1980) | .. | 149.00 |
| 14. | Percapita Bank Advances (Rs., 1983) | .. | 1731.00 |
| 15. | Percapita Bank Deposits (Rs., 1983) | .. | 1605.00 |
| 16. | Population below Poverty Line (percent, 1977-78) | .. | 47.71 |
| | (Rural) | .. | 55.85 |

**Source :** Compiled from (a) Census of India - 1981, Series 12, Maharashtra, Primary Census Abstract, Part IIB, Govt. of Maharashtra, Bombay, 1983. (b) Profiles of Districts, Part 1: A-K and Part 2: L-Z, Centre for Monitoring Indian Economy, Bombay, 1985.

**II. Health Programmes' Data** (actual numbers, 1983-84 unless otherwise specified)

| | | | |
|---|---|---|---|
| 1. | BCG Vaccinations | .. | 27.77 lakhs |
| | Infants (58% of infant population) | .. | 8.89 lakhs |
| 2. | DPT Vaccinations | .. | 28.91 lakhs |
| 3. | Polio Vaccination | .. | 19.74 lakhs |
| 4. | Tetanus Toxoid (Mothers) | .. | 18.73 lakhs |
| 5. | Tetanus Toxoid (upto 16 years) | .. | 17.07 lakhs |
| 6. | Estimated Eligible Couples | .. | 113.68 lakhs |
| 7. | Couples currently protected by : | | |
| | a) Sterilisation | .. | 44.93 lakhs |
| | b) IUCD | .. | 6.31 lakhs |
| | c) Other methods | .. | 3.61 lakhs |
| 8. | Tubectomies | .. | 4.36 lakhs |
| 9. | Vasectomies | .. | 2.15 lakhs |
| 10. | IUCDs | .. | 7.26 lakhs |
| 11. | Compensations paid : | | |
| | a) To F.P. Acceptors | .. | 652.34 lakhs |
| | b) To doctors and promoters | .. | 61.96 lakhs |
| | c) For drugs, diet charge etc. | .. | 260.09 lakhs |

**Source :** Compiled from Performance Budget, 1985-86, Family Welfare, Public Health Dept., Govt. of Maharashtra, Aurangabad, 1985.

## III. Other Health Services Data

| | | | |
|---|---|---|---|
| 1. | Live Birth Rate (per 1000 population, 1981) | .. | 28.5 |
| | (Rural) | .. | 30.4 |
| 2. | Death Rate (per 1000 population, 1981) | .. | 9.6 |
| | (Rural) | .. | 10.6 |
| 3. | Infant Mortality Rate (per 1000 live births) | .. | 75.0 |
| | (Rural) | .. | 84.0 |
| 4. | Doctors registered with Maharashtra Medical Council (1983) | .. | 34103 |
| 5. | Nurses/Midwives/ANMs and Health Visitors registered in the state (1982) | .. | 68453 |
| 6. | Registered Ayurvedic, Unani and Homeopathic Doctors (1982) | .. | 36047 |
| 7. | Disabled population (1980) | .. | 82392 |
| 8. | Leprosy Prevalence Rate (per 1000 population 1983-84) | .. | 6.37 |
| | estimated cases (1981) | .. | 4 lakhs |
| | cases under treatment (March 1984) | .. | 3.76 lakhs |
| 9. | State Health Expenditure (Rs.per capita, 1981-82) | .. | 33.26 |
| | Family Welfare Expenditure (Rs.per capita, 1981-82) | .. | 3.10 |

**Source :** Compiled from Health Statistics of India - 1984, CBHI, MHFW, New Delhi, 1984.

## IV. Health Care Facilities

### 1. Ownership-wise Urban and Rural Distribution of Hospitals and Beds in Maharashtra - 1979

| Location | Ownership | | | | | | Total | |
|---|---|---|---|---|---|---|---|---|
| | Government | | Municipal | | Voluntary (Pvt.) | | | |
| | Hospitals | Beds | Hospitals | Beds | Hospitals | Beds | Hospitals | Beds |
| Rural | 8 (4.6) | 577 (1.9) | 51 (7.8) | 2976 (11.3) | 38 (27.7) | 1115 (10.6) | 97 (10.0) | 4668 (6.9) |
| Urban | 165 (95.4) | 30024 (98.1) | 605 (92.2) | 23368 (88.7) | 99 (72.3) | 9388 (89.4) | 869 (90.0) | 62780 (93.1) |
| Total | 173 (100) | 30601 (100) | 656 (100) | 26344 (100) | 137 (100) | 10503 (100) | 966 (100) | 67448 (100) |

(Figures in parentheses are percentages)

**Source :** Compiled from Directory of Hospitals in India - 1981, CBHI, MHFW, New Delhi, 1982.

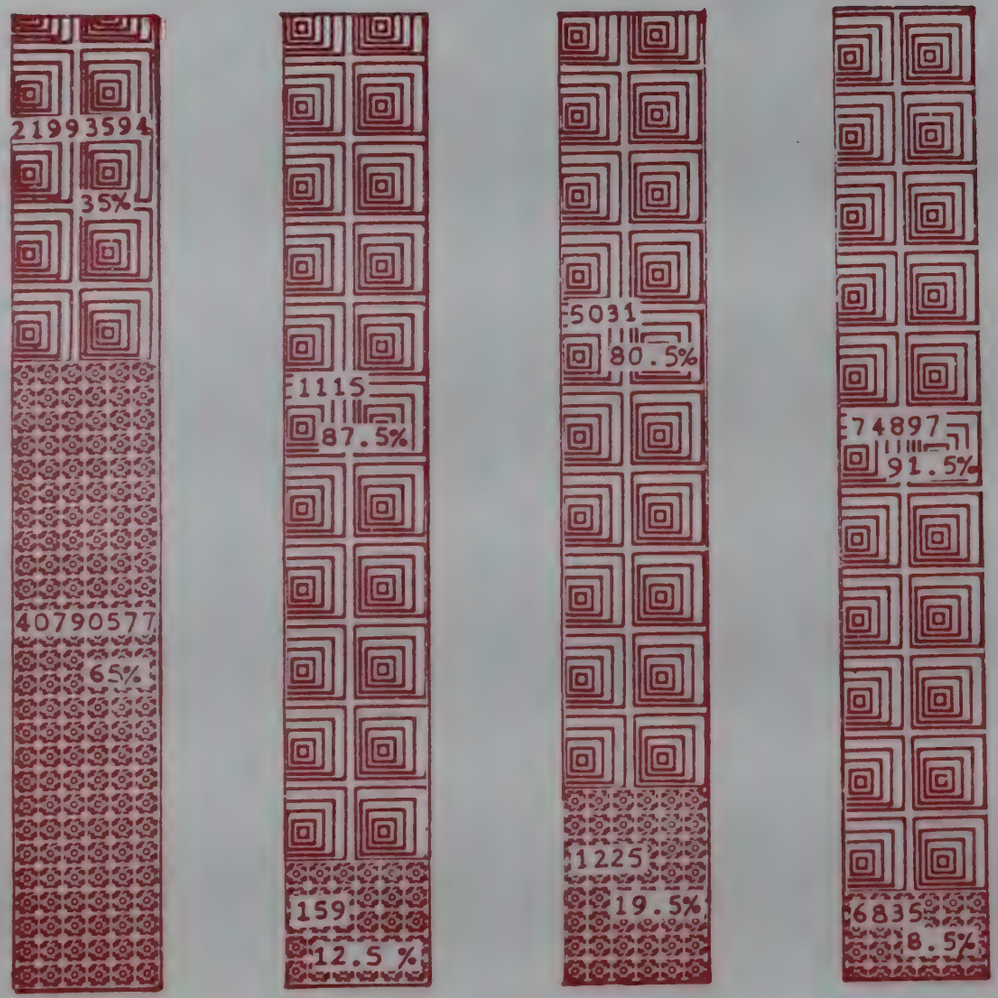
### 2. Public Health Facilities in Rural Maharashtra (1984)

| Health Facility | Total Number | Rural Population per Facility |
|---|---|---|
| PHCs | 1539 | 26,504 |
| Sub-centres | 5741 | 7,105 |
| Rural Hospitals | 146 | 2,79,000 |
| Doctors at PHCs | 3207 | 12,719 |
| ANMs (in Position) | 6004 | 6,794 |
| Village Health guides (in position) | 41388 | 980 |

**Source :** Compiled from Health Statistics of India - 1984, CBHI, MHFW, New Delhi, 1984.

# 3. HEALTH INFRASTRUCTURE OF MAHARASHTRA

## RURAL-URBAN DIFFERENTIALS




POPULATION (1981)

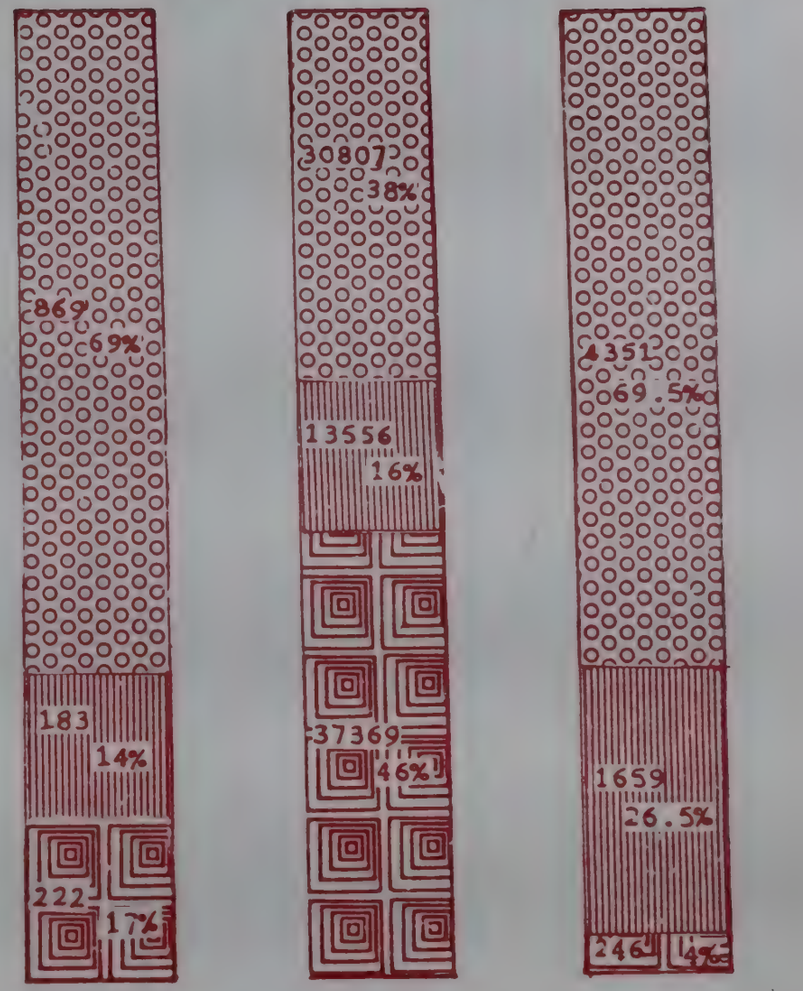
HOSPITALS (1984)
One hospital per 2.56 Lakh rural population.

DISPENSARIES (1984)
One dispensary per 33293 rural population.

HOSPITAL BEDS (1984)
One hospital bed per 5968 rural population.

RURAL URBAN

## BY OWNERSHIP.




HOSPITALS (1984)

HOSPITAL BEDS (1984)

DISPENSARIES (1984)

GOVT. LOCAL BODIES VOL.(PVT.)

## V. Health Financing

### 1. Health Expenditure of Maharashtra State (1983-84 actuals)** (excludes medical education and teaching hospitals)

(Rs. lakhs)

| Type of Expenditure | | Public Health and Sanitation | Family Welfare* | Medical (non-teaching govt. hosp.) |
|---|---|---|---|---|
| Direction and Administration | Salaries | 337.45 | 327.96 | 51.28 |
| | Travel and vehicle exp. | 30.23 | 39.21 | 4.16 |
| | Office exp. | 24.62 | 50.50 | 14.84 |
| | Materials and supplies | 133.76 | 348.17 | 4.77 |
| | Other | 0.71 | 178.46 | 4.18 |
| Programme Component | Salaries | 1715.48 | 808.69 | 1412.99 |
| | Travel and vehicle exp. | 140.71 | 104.20 | 50.33 |
| | Office exp. | 110.67 | 65.04 | 117.38 |
| | Materials and supplies | 950.56 | 515.61 | 643.65 |
| | Other | 85.46 | 171.38 | 277.36 |
| | Compensation paid for F.P. | - | 1740.43 | - |
| Grant in Aid | | 3063.41 | 354.49 | 353.56 |
| Other | Salary | 103.89 | 93.05 | 25.49 |
| | Other | 119.71 | 463.97 | 6.10 |
| | TOTAL | 6816.66 | 5311.16 | 2966.09 |

* includes USAID and CHG component of Rs.916.35 lakhs.
** the expenditure indicated are combined plan and non-plan.

**Sources :** Compiled from Performance Budgets, 1985-86 (a) Public Health and Sanitation, (b) Family Welfare and (c) Medical (non-teaching Govt. Hospitals), Public Health Dept., Govt. of Maharashtra, Aurangabad, 1985.

2. Sixth and Seventh Five Year Plan Outlays for the Health Sector - Maharashtra State

(Rs. in lakhs)

| | Medical Education* | Public Health** | Total Plan Outlay |
|---|---|---|---|
| **SIXTH PLAN** | | | |
| Allocation 1980-85 | 2565.00 | 6381.00 | 617500.00 |
| Anticipated Expenditure | 3976.21 | 11631.19 | -- |
| 1983-84 Actuals | 588.61 | 3209.99 | - |
| **SEVENTH PLAN** | | | |
| Allocation 1985-90 | 5063.00 | 31337.00 | 1050000.00 |
| Approved 1985-86 | 554.00 | 4703.00 | -- |

* includes ESIS; ** includes medical and family welfare.

**Source :** Compiled from Seventh Five Year Plan, 1985-90 and Annual Plan 1985-86 (Parts One and Two), Planning Dept., Govt. of Maharashtra, 1985.

## VI. Morbidity and Mortality

### 1. Reported Cases and Deaths in Maharashtra : Selected Diseases

| Cholera | | Dysentry | | Gastro | | Malaria | |
|---|---|---|---|---|---|---|---|
| Cases | Deaths | Cases | Deaths | Cases | Deaths | Cases | Deaths |
| 1239 | 36 | 103868 | 375 | 39685 | 759 | 82983 | 1 |

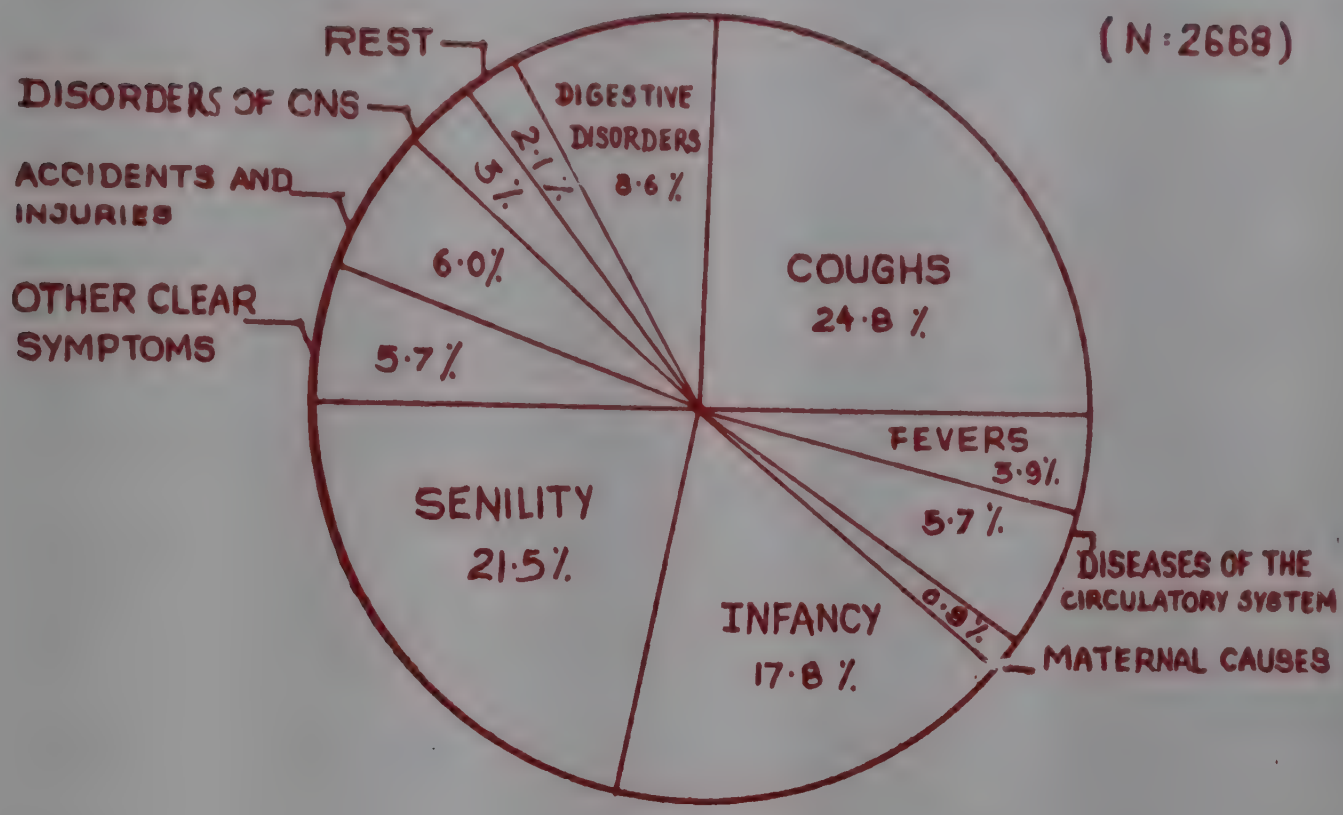
| Diptheria | | Pertussis | | Tetanus | | Measles | |
|---|---|---|---|---|---|---|---|
| Cases | Deaths | Cases | Deaths | Cases | Deaths | Cases | Deaths |
| 876 | 48 | 14777 | 7 | 3397 | 1017 | 21350 | 44 |

| Polio | | Tuberculosis | | Enteric Fever | | Chicken Pox | |
|---|---|---|---|---|---|---|---|
| Cases | Deaths | Cases | Deaths | Cases | Deaths | Cases | Deaths |
| 1409 | 89 | 11563 | 1945 | 17189 | 123 | 4464 | 7 |

| Influenza | | Viral Hepatitis | | Viral Encephatitis | | Meningococal Infection | |
|---|---|---|---|---|---|---|---|
| Cases | Deaths | Cases | Deaths | Cases | Deaths | Cases | Deaths |
| 503761 | 1 | 20147 | 654 | 1691 | 440 | 1258 | 228 |

**Source :** Compiled from Health Statistics of India - 1984, CBHI, MHFW, New Delhi, 1984.

## 2. CAUSE OF DEATH BY MAJOR CAUSE GROUPS AND THEIR BREAK-UP IN MAHARASHTRA (RURAL) 1980




**Coughs (n = 662)**

| | |
|---|---|
| Asthma | 37.8% |
| T.B. (Lungs) | 28.5% |
| Pneumonia | 23.3% |
| Bronchitis | 7.8% |
| Other | 2.6% |

**Infancy Diseases (n = 475)**

| | |
|---|---|
| Prematurity | 65.7% |
| Respiratory infection of new born | 12.4% |
| Malnutrition | 5.9% |
| Diarrhoea of new born | 1.7% |
| Convulsions | 5.5% |
| Others | 88.8% |

**Fevers (n = 105)**

| | |
|---|---|
| Typhoid | 30.5% |
| Influenza | 3.8% |
| Malaria | 0.9% |
| Not classifiable | 64.8% |

**Digestive Disorders (n = 230)**

| | |
|---|---|
| Gastroenteritis | 6.1% |
| Debility and Malnutrition | 41.7% |
| Acute Abdomen | 13.0% |
| Peptic ulcers | 7.4% |
| Not classifiable | 31.3% |

**Clear Symptoms (n = 152)**

| | |
|---|---|
| Cancer | 42.1% |
| Tetanus | 13.2% |
| Jaundice | 14.5% |
| Cirrohsis of liver | 22.4% |
| Diabetes | 3.3% |
| Measles | 0.7% |
| Others | 3.8% |

**Sources :** Compiled from Survey of Causes of Death (Rural) 1980 - A Report, Office of the Registrar General Ministry of Home Affairs, New Delhi, 1982.

## APPENDIX 'C'

### Addresses of Other NGOs Identified

Given below are the addresses of all the other NGOs we identified from various sources :

**I. NGOs giving inadequate information**

Mrs. Bastikar,
Kailas Trust,
At-Post : Verul,
**Dist: Aurangabad**

Medico Friend Circle,
Gopuri,
**Wardha 442 001**

Community Outreach Programme,
International House,
21, YMCA Road,
**Bombay 400 008**

Sadguru Seva Sangh,
C/o. Mafatlal House,
Backbay Reclamation,
**Bombay 400 021**

Chargaon Samajik Arogya Sanstha,
Bhiwandiwalla Bungalow,
Uran,
**Dist : Raigad**

Polyolefins India Ltd.,
Mafatlal Centre,
Nariman Point,
**Bombay 400 021**

Investment in Maharashtra,
250, Sneh Sadan,
Shaniwar Peth,
**Pune 411 013**

Kashtachi Bhakar,
C/o. Dr. Sukhatme,
Maharashtra Association for Cultivation of Science,
**Pune 411 004**

Community Aid & Sponsorship Programme (CASP),
175, Dadabhai Naoroji Road,
**Bombay 400 001**

Gram Swarajya Samiti,
Shahada Taluka,
**Dist : Dhulia**

Matru-Seva Sangh,
North Ambazari Road,
**Nagpur 440 010**

Indian Red Cross Society Health Centre & Dispensary,
Red Cross Road,
P.O. Nasik,
**Dist : Nasik 422 001**

Indian Sponsorship Committee,
P.B. No.6060,
Colaba,
**Bombay 400 005**

**II. NGOs who did not respond**

Mr. S.V. Vikhe Patil,
Prawara Medical Trust,
At-Post: Loni, Shrirampur,
**Dist : Ahmednagar**

Patricia Gokhale,
KARMA, 353, Samarth Nagar,
Dahiwali, Tal: Karjat,
**Dist. Kolaba**

Mary Wanless Hospital,
**Kolhapur - 416 003**

Kasturba Seva Kendra,
Thakli,
P.O. Hingoli - 431 513
**Dist. Parbhani**

Willis Pierce Memorial Hospital,
Wai,
**Dist. Satara**

Dorabji Tata Trust Rural Welfare Board,
Bombay House,
Homi Mody Street,
**Bombay 400 001**

Satya Niketan,
817, Sadashiv Peth,
**Pune 411 030**

Nagpur Multipurpose Social Service Society,
Archbishops' House,
Kamptee Road,
**Dist : Nagpur 440 001**

Mr. M.R. Pulsay, Secretary,
Akhil Bharatiya Sri Gurudeo Seva Mandal,
Gurukunj Ashram,
**Dist : Amravati 440 601**

Dr. Vyankatesh Kabde,
Dang Seva Mandal,
Sharanpur Road,
**Nasik 442 002**

Dr. Modak,
Sahyadri Vikas Mandal,
Khanapur, Tal : Haveli,
**Pune.**

Appasaheb Patwardhan Memorial Trust,
Mahatma Gandhi Seva Mandir,
252, S.V. Road, Bandra (W),
**Bombay 400 050**

Agricultural Development & Social Welfare Project (YERLA)
Christian Council Lodge,
Civil Lines,
**Nagpur 440 001**

Richardson Leprosy Hospital,
Miraj,
**Dist : Sangli 416 410**

Rural Services in Health Society,
106, Shivaji Nagar,
**Dist : Sangli 416 416**

Mara Sadam Hospital,
P.O. Nirmal,
**Dist : Thane 401 304**

Institute of Cultural Affiars, (INDIA)
Maharashtra State Administrative Staff College,
P.O. Box 660, GPO,
**Bombay 400 001**

Adivasi Seva Mandal,
Elphinstone Building,
6, Veer Nariman Road,
**Bombay 400 023**

Indian Council of Social Welfare,
175, D.N. Road,
**Bombay 400 001**

Siemens Employees Rural Development Society,
1344, Dr. Annie Besant Road,
Worli,
**Bombay 400 018**

Nirmiti Youth Foundation
B/3, Chitra Amrut Kumbha Society,
Bhavani Shankar Road, Dadar,
**Bombay 400 028**

Sevilavya Seva Sangh,
C/o Mrs. Prabha Makharia,
68, Asholia Apartments, 12th Floor, Napean Sea Road,
**Bombay 400 006**

N. Sethia Foundation,
222, Nariman Point,
Maker Chamber IV,
**Bombay 400 032**

Gandhi Maternity & Nursing Home,
Akluj,
**Dist : Solapur 413 101**

ASPEE Charitable Trust,
P.B.No. 7602,
Malad,
**Bombay 400 064**

Rural Development Foundation,
Mackinon Mackenzie Building,
Ballard Estate,
**Bombay 400 038**

Rotary Club of Bombay,
Red Cross Building, 2nd Floor,
Shaheed Bhagat Singh Road,
**Bombay 400 038**

Adivasi Gram Seva Sangh,
Kainad,
**Dist : Thane**

ISKON Rural Development Project,
Hare Krishna Road,
Juhu Beach,
**Bombay 400 049**

Manav Utkarsha Laksha Dhama Sanstha,
159, Churchgate Reclamation,
**Bombay 400 020**

Tata Engineering & Locomotive Co.,
Bombay House,
24, Homi Mody Street,
**Bombay 400 023**

M/s. Hoschest Dyes & Chemicals Ltd.,
193, Backbay Reclamation,
**Bombay 400 021**

Servants of India Society,
846, Shivaji Nagar,
**Pune 411 004**

Walchandnagar Industries,
Construction House,
Walchand Hirachand Marg,
**Bombay 400 038**

M/s. Associated Cement Cos. Ltd.,
**Chandrapur**

National Christian Council of India,
Christian Council Lodge,
Civil Lines,
**Nagpur 440 001**

Gram Vikas Prathisthan,
Khed,
**Dist : Ratnagiri**

Socio-Economic Development Corporation,
Khurudwadi,
Tal : Gangakher,
**Dist : Parbhani**

Balaji Trust (Pune Branch),
Schavan House Society,
Mingne,
**Pune 411 029**

Ashiwini Rural Cancer Relief & Research Society,
C/o Dr. B.M. Vene,
Lalchand Lane, Barshi,
**Dist : Sholapur**

M/s. Larsen & Toubro Ltd.,
L & T House,
Ballard Estate,
**Bombay 400 038**

National Council of Women in India,
Lakeki Model Colony,
**Pune 411 016**

## III. NGOs not traceable (Mail returned)

Kamal Arogya Mandir,
**Yeotmal 445 001**

Kokan Unnathi Mitra Mandal,
222, Maker Chambers,
Nariman Point,
**Bombay 400 032**

Shriwardhan Matdar Sangh,
222, Maker Chambers,
Nariman Point,
**Bombay 400 032**

Lata Khambadkone Ramesh Rao Rural Development &
Medical Research Trust,
C/o. 12, Ajinkya Mansion, Hughes Road,
**Bombay 400 007**

Kishanchand Rural Development Trust,
D-E, Dr. Moses Road,
Jacob Circle,
**Bombay 400 011**

Shree Purnanad Manav Seva Trust,
Seetai, 4th Floor, Pandurangwadi,
Goregaon,
**Bombay 400 063**

Sadguru Gramin Vikas Sanstha,
Hadgaon,
**Dist : Nanded**

Dattatraya Rural Development Society,
Mahagaon,
**Dist : Yeotmal**

Sadguru Rural Development Society,
Umerkhed,
**Dist : Yeotmal**

Satpuda Sarvodaya Mandal,
Dhodgaon,
**Dist : Dhulia**

Raigad Zilla Pratisthan,
222, Maker Chambers,
Nariman Point,
**Bombay 400 032**

Ambet Pratisthan,
222, Maker Chambers,
Nariman Point,
**Bombay 400 032**

Ulhas Parisar Pratisthan,
C/o. Dr. K.R. Taraskar,
98, Seth Motishah Lane,
**Bombay 400 011**

Sadguru Seva Mandal,
Hedvi,
Tal : Guhagar,
**Dist : Ratnagiri**

Sadguru Gramin Vikas Sansthan,
Hingoli,
**Dist : Parbhani**

The Narayan Rural Development Society,
Dhanki,
**Dist : Yeotmal**

Sadguru Rural Development Society,
Pusad,
**Dist : Yeotmal**

## APPENDIX 'D'

## QUESTIONNAIRE USED FOR NGOs

Date :

### Voluntary Agency Abstract

Please complete the following Questionnaire before 30th April, 1984 and post it to the following address

The Foundation for Research In Community Health,
84-A, R.G. Thadani Marg,
Worli, Bombay 400 018.

(Please use extra sheets wherever required)

A. Name of Voluntary Organisation :

B. Affiliation :
(1. Political, 2. Religious, 3. Corporate,
4. Other (specify), 5. None)

C. Name & Designation of Project In-charge/ Coordinator :

D. **Commencement Profile :**

1. Baseline Survey : YES/NO
2. Month and year of commencement :
3. Villages & Population covered during first year of operation :
   Villages :
   Population :
4. First Action Programme :
   i) Health :
   ii) Non-Health : (specify)
   iii) Both :
5. List objectives at commencement of project :
6. Organisational structure during first year of project (list all staff and numbers) :
7. List all activities undertaken during first year of commencement :
8. Why was the geographic area selected? :
9. Who or what provided the entry point into the villages ? :
10. Main causes of morbidity and mortality at the point of agency's intervention/ first year of commencement :
    Morbidity :
    Mortality :

E. **Community Health Services :**

1. Month & Year when community health services commenced :

   Month :
   Year :

2. First year coverage :

   Villages :
   Population :
   No.of village level health workers :
   Other support staff :

| | Category | Number |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |
| 4) | | |

3. Present coverage :

   Village :

   (Please see 'M' appendix)

   Population :

   No. of village level health workers :

   Other support staff :

| | Category | Number |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |
| 4) | | |
| 5) | | |

4. How were village level health workers selected ? :

5. Who trained them and for how long ? :

6. What are the main functions they perform ? (Services rendered) :

7. Who pays them and how much ? :

8. Are villagers (beneficiaries) charged for services rendered by the village health workers ? : YES/NO
   If yes, how much for a single days' medicine ?

F. **Support (Referral) Health Services** :

Give a brief description of all supportive health services presently provided, how delivered and at what cost to the beneficiary ? (Example : Hospital, Dispensary, Mobile team, Sub-centres, Nurse, Doctors, Specialists, Insurance, etc...) :

G. **Non-Health Services/Activities** :

Give a brief description of all types of activities undertaken (other than health), how delivered, directed towards whom and for what purpose (with a statistical profile wherever possible)

H. **General Information** :

1. Present objectives, if different from earlier, of the project
2. Present organisational structure of the project (list all staff and numbers) :
3. Geographical location of project Plains, Forest, Coastal, Hilly, Tribal, etc.) :
4. Is your project in collaboration with the Government ? : YES/NO

5. What type of data and records are maintained by the project ? :

6. Has an evaluation (external or internal) of your project ever been conducted? : YES/NO

   If yes, can a copy of the evaluation be made available to us ?

7. Do the villages covered by you form a continum or they are dispersed ? :

   1. Continum :
   2. Dispersed :

8. Which political party controls the Panchayat Samiti and Zilla Parishad in the Project area ? :

I. **Socio-Economic Profile :**

1. List dominant castes/communities in the project area (all which are more than 10%) and their percentages :

2. Give the percentage/proportion of following variables in the project area :

   a) Educated/Literate :
   b) Agricultural workers (Landless) :
   c) Small/marginal cultivators (upto 5 acres) :
   d) Current birth rate (per 1000) :
   e) Current death rate (per 1000) :
   f) Infant mortality rate (per 1000 live births)
   g) Population getting perennial potable water supply :
   h) Number of villages electrified :
   i) Number of villages having access to public transport (within one km.) :
   j) Number of private medical practitioners in project area :

3. List main crops grown in the project area :

4. If irrigation facilities available for second and/third crop then for what percentage of cultivable land and for which crops ? :

J. **Disease Profile :**

1. Per 1000 population estimate in the project area of prevalence of :

   a) Leprosy :
   b) Tuberculosis :
   c) Malaria :
   d) Night blindness (Xeropthalmia) :

2. Major morbidity and mortality factors in the project are : (wherever possible give a statistical profile ) :

   a) Morbidity :
   b) Mortality :

K. **Sources and Use of Funds :**

1. List all sources of funds that support the functioning of the project (indicate percentage of different sources) :

2. Percentage allocation of funds to following functional areas :

   1. Health and related activities :
   2. Non-health activities :
   3. Staff salaries :
   4. Programme (all) components materials :
   5. Transport and overheads :

3. Last one year's budgeted/actual expenditure major head-wise :

L: **Problems Encountered :**

Give a brief summary of political, socio-cultural and other problems encountered in functioning in the project area ? :

M. **Appendix :**

Please append a list of all villages (and if available a Map) covered in the community health programme in the following format. :

| Name of Village | Taluka | Population | Distance (Km) from main Health Centre | Distance from nearest S.T. Bus Stop |
|---|---|---|---|---|
| | | | | |

(on separate sheet)

(Any other information that you feel is not covered above may be added on a separate sheet)

**// THANK YOU //**

## APPENDIX 'E'

## SELECT BIBLIOGRAPHY

In this selection most of the writings in the debate on community development in the 1950s and the 1960s are excluded due to lack of space. Likewise numerous annual reports and other documents of the NGOs included in this study are excluded as they can be obtained directly from the respective NGO.


"Alma-Ata 1978: Primary Health Care" Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September, 1978 World Health Organisation, 1978.

"Alternative Approaches to Health Care" Report of a Symposium Organised Jointly by ICMR and ICSSR from 27-30 Oct, 1976 at Hyderabad, Indian Council of Medical Research, New Delhi, 1976.

Ambasta Asheesh, Baxamusa Ramla, Dighe Sunil, Dighe Usha, Duggal Ravi, Savur Manorama, Srinivasan Usha, "Corporate Sector in Rural Development Under IRDP" Department of Sociology, University of Bombay, Bombay, 1985.

"Annual Report: 1984-85" Ministry of Health and Family Welfare, Government of India, New Delhi.

"Annual Vital Statistics of the Maharashtra, 1978" Director of Health Services, Government of Maharashtra, Pune, 1980.

Apte D P, "Prospects of Development in a Backward Region: A Socio-economic Survey of 15 villages in Kolaba District" Agro-economic Research Centre, Pune, 1975.

Arole Mabelle and Arole Rajnikant, "A Comprehensive Rural Health Project in Jamkhed (India)" in Newell Kenneth W (Ed), **Health by the People**, World Health Organisation, Geneva, 1975.

Asrani R C, "Role of the Voluntary Sector in Health and Family Planning, Immunisation and Leprosy" Paper presented at Seminar on the Role of Voluntary Sector in Social Services, Vigyan Bhavan, New Delhi, June, 23-24, 1982. Published by The Central Social Welfare Board, New Delhi.

Baig Tara Ali, "Voluntary Action: Retrospect and Prospect" **Mainstream,** Vol.XXIII No.20, January 12, 1985.

Bainbridge J and Sapirie S, "Health Project Management: A Manual of Procedures for Formulating and Implementing Health Project" World Health Organisation, Geneva, 1974.

Banerji D, "Poverty Class and Health Culture in India" Prachi Prakashan, New Delhi, 1982.

Bannerjee Usha, "Role of Voluntary Organisations in Health Care in India" Paper presented at the Seminar on the Role of Voluntary Sector in Social Services, Vigyan Bhavan, New Delhi, June 23-24, 1984, Published by the Central Social Welfare Board, New Delhi.

"Basic Statistics Relating to the Indian Economy" Vol.2 States, Economic Intelligence Service, Centre for Monitoring Indian Economy, Bombay, September, 1984.

Baxi Upendra, "For Bunker Roy, a Word of Advice" **Mainstream,** Vol.XXIII, No:32, April 6, 1985.

Bhattacharjee Abhijit, "Voluntary Agencies: Identity Crisis" **Mainstream,** Vol.XXIII No: 48, July 27, 1985.

Bose Ashish, "Community Health Worker Scheme: an Indian Experiment" in Morley David, Rohde Jon and Williams Glen, **Practising Health for All,** Oxford University Press, Oxford, New York, Toronto, 1984.

Bose Ashish, and Desai PB, "Studies in Social Dynamics of Primary Health Care" Hindustan Publishing Corporation (India), New Delhi, 1983.

Brenton Maria, "The Voluntary Sector in British Social Services" Longman, London and New York, 1985.

"Catalogue of Agencies Reaching Poorest Women in India" Institute of Social Studies, New Delhi, 1981.

"Census of India:1981, Series-1, India, Report and Tables Based on 5 percent Sample Data" Government of India, New Delhi, 1984.

"Census of India: 1981, Series-12, Maharashtra, General Population Tables, Part IIA" Government of Maharashtra, Bombay, 1984.

"Census of India: 1981, Series-12, Maharashtra, Primary Census Abstract, Part II-B", Government of Maharashtra, Bombay, 1983.

"Central Aid for Health and Family Planning to Voluntary Organisations" Ministry of Health and Family Planning, Government of India, New Delhi, 1976.

Chandra Subhash, Punalekar S P, "Urban Community Development Programme in India" National Institute of Public Cooperation and Child Development, New Delhi, 1975.

Chatterjee Mirai, "Community Participation in Rural Health Care: The Indian Experience" (Thesis for Bachelor of Arts Degree), Harvard University, Cambridge, Massachusetts, 1982.

"A Classified List of Voluntary Agencies in India (Information Base on Voluntary Sector)" Academy of Development Sciences, Kashele, Tal. Karjat, Dist. Raigarh, Maharashtra, 1980.

Colchester Marcus, "An End to Laughter? Hydropower Projects in Central India" Survival International, London.

"Collaboration with Non-Governmental Organisations in Implementing the Global Strategy for Health for All Report of the Technical Discussion" Thirty Eighth World Assembly, A38/Technical Discussion/4, World Health Organisation, 14 May 1985.

Dyalchand Ashok, Soni M Ibrahim, "Evaluation in Primary Health Care a Case Study from India" In Morley David, Rohde Jon and Williams Glen, **Practising Health for All** Oxford University Press, Oxford, New York, Toronto, 1984.

"A Directoryof Community Health Care and Educational Centres in Asia" The Asian Health Institute, Nagoya, Japan.

"Directory of Hospitals in India - 1981" Central Bureau of Health Intelligence, Ministry of Health and Family Welfare, Government of India, New Delhi, 1982.

"Directory of Non-Institutional Services in India for Children in Need of Care and Protection" Tata Institute of Social Sciences, Bombay, 1984.

"Director of Public Trusts - Greater Bombay, Bombay Suburban District - Volume I" Government of Maharashtra, Bombay, 1979.

"Directory of Public Trusts - Greater Bombay, Bombay Suburban District - Volume II" Government of Maharashtra, Bombay, 1980.

"Directory of Public Trusts - Greater Bombay, Bombay Suburban District - Volume III" Government of Maharashtra, Bombay, 1981.

"Directoryof Services for Women in Bombay" Tata Institute of Social Sciences, Bombay.

"Directory of Voluntary Action" Association of Voluntary Agencies for Rural Development, New Delhi, 1979.

"Directory of Voluntary Health Care Institutions and Programmes in India" Voluntary Health Association of India, New Delhi, 1981.

Djukanovic V and Mach EP, "Alternative Approaches to Meeting Basic Health Needs in Developing Countries" A Joint UNICEF/WHO Study, World Health Organisation, Geneva, 1975.

Dogra Bharat, "Invading by Charity" **Onlooker,** November 8-22, 1984.

Durrany K S, "Worker Management Relationship in Charitable Institutions - A Survey" Research and Training Programme, Hind Mazdoor Sabha, New Delhi, 1985.

Dutt Dev, "Gandhian in the Dock - A Damning Indictment of Vested Interests" **The Week,** 27 January, 1985.

"Facts and Figures, Health Services in Maharashtra, April 1977" The Directorate of Health Services, Bombay, 1978.

Ferranti David de, "Paying for Health Services in Developing Countries - An Overview" World Bank Staff Working Papers No:721, The World Bank, Washington DC, 1985.

"Fifty Second Annual Report - January to December, 1982" All India Women's Conference, Bombay Branch, Bombay.

Fonaroff Arlene, "Community Involvement in Health Systems for Primary Health Care" World Health Organisation, Geneva.

"Gandhi Memorial Leprosy Foundation and Medical Profession" Gandhi Memorial Leprosy Foundation, Wardha, 1983.

"Grants-in-aid to Voluntary Agencies - A Study of Procedures, Process and Problems" Central Institute of Research and Training in Public Co-operation, New Delhi, 1969.

"Greater Bombay Statistical Information" The Foundation for Research in Community Health, Bombay, 1980 (mimeo);.

"Harnessing Voluntary Effort for Social and Economic Development" **Organiser**, April 7, 1985.

"Health for All: An Alternative Strategy" Report of a Study Group set up Jointly by the ICSSR and the ICMR, Indian Institute of Education, Pune, 1981.

"Health, Nutrition, and Family Planning in India: A Survey of Experiments and Speical Projects" World Bank Working Paper No.507, The World Bank, Washington D.C., 1982.

"Health Services in Maharashtra, December 1978" The Directorate of Health Services, Bombay, 1979.

"Health Statistics of India - 1984" Central Bureau of Health Intelligence, Ministry of Health and Family Welfare, Government of India, New Delhi, 1984.

Hulbe SK, "New Horizons in University Education, Part II - Education for Development and Social Justice" (Revised Edution), Centre for Studies in Rural Development, Ahmednagar College, Ahmednagar, 1977.

"Integrated Rural Health and Population Project - Project Paper" United States Agency for International Development (USAID), New Delhi, 1980.

"Inventory of Basic Services to Children in Asia" United Nations Children's Fund (UNICEF), Rosca, New Delhi, 1981.

Jajoo Ulhas, "When the Search Began" Mahatma Gandhi Institute of Medical Sciences, Sevagram, Wardha, 1984.

"**Jeevan - Kushtharogyache Mukhpatra**" published by Vidarbha Maharogi Seva Mandal, Tapovan, Amravati (Marathi).

Jelliffe Derrick B and Jelliffe EF Patrice, "Community Action - Family Nutrition Programmes" Proceedings of a joint IUNS/UNICEF/ICMR Working Conference held at the National Institute of Nutrition, Hyderabad, October 17-21, 1977, Indian Council of Medical Research, New Delhi, 1977.

Joshi D C, Krishnayya J G, Das Gupta C B, "Design of Voluntary Health Projects - A Case Study of the Comprehensive Rural Health Project, Jamkhed" Systems Research Institute, Pune, August, 1978.

Kohli Madhu, "Voluntary Action in India - Some Profiles" National Institute of Public Cooperation and Child Development, New Delhi.

Kothari Rajni, "Non-party Political Process" **Economic and Political Weekly**, Vol.XIX, No.5, February 4, 1984.

Kotval Indira, "Directory of Community Health Projects in India" Foundation for Research in Community Health, Bombay, 1983 (unpublished).

Krishnamachari V T "Community Development in India" The Publications Division, Ministry of Information and Broadcasting, Government of India, New Delhi, 1958.

Kulkarni Manu K "Community Participation in Development" **Mainstream,** Vol.XXI, No:47, July 23, 1983.

Lalitha N V, "Financial Assistance to Voluntary Organisations for Social Development - A Source Book" National Institute of Public Cooperation and Child Development, New Delhi, 1984.

Lalitha N V, Kohli Madhu, "Status of Volutary Effort in Social Welfare" National Institute of Public Cooperation and Child Development, New Delhi, 1982.

Mabry Esther G, "Planning a Community Health Programme" The Christian Medical Association of India, Bangalore, 1972.

Mahler H, "Voices in Harmony for Health for All" Director-General's Address in presenting report for 1982-83 to The Thirty-seventh World Health Assembly, WHA 37/DIV/4, World Health Organisation, 9 May, 1984.

Mathai Thomas P, "An Unbeaten Track - A Report on Anandwan, An Experience in Community Development" UNICEF, New Delhi, December, 1983.

Mishra Madhu S, "Directory of Voluntary and Other Organisations in Rural Development - Volume I to VI" Indian Institute of Management, Calcutta.

Mukherji Partha Nath, "Agrarian Mobilisations and Social Change" **Mainstream,** Vol.XXII No:25, February, 18, 1984.

Mukhopadhyay Maitreyee, "Human Development through Primary Health Care - case studies from India" In Morley David, Rohde Jon and Williams Glen, **"Practising Health for All",** Oxford, University Press, Oxford, New York, Toronto, 1984.

Naik J P "An Alternative System of Health Care Service in India: Some Proposals" Allied Publishers Private Limited, New Delhi, 1977.

"The Narangwal Population Study: Integrated Health and Family Planning Services" Rural Health Research Centre, Narangwal, Punjab, 1975.

"National Health Policy" Ministry of Health and Family Welfare, Government of India, New Delhi, 1983.

Ninan Sevanti and Sharma Kalpana, "Poser for Voluntarism" **Indian Express,** Bombay, November 24, 1984.

Pandey Shashi, "Role of Voluntary Action in Rural India" **South Asia Bulletin,** Vol.IV, No.2, Fall 1984.

Parikh Dr (Mrs) Indumati, "An Experiment in Community Involvement in Family Planning in a Metropolitan Slum" Centre for the Study of Social Change Bombay, 1978.

"Performance Budget, 1985-86, Family Welfare", Public Health Department, Government of Maharashtra, Aurangabad, 1985.

"Performance Budget, 1985-86, Public Health and Sanitation" Public Health Department, Government of Maharashtra, Aurangabad, 1985.

Perinbam Lewis, "Voluntary Agency Cooperation and Opportunity" ACFOA Research and Information Service, Australian Council for Overseas Aid, December, 1981.

"Proceedings of the Conference of Non-Government Organisations supporting Family Planning" Family Planning Association of India, Bombay, 1976.

"Profiles of Districts, Part I: A-K and Part 2: L-Z" Centre for Monitoring Indian Economy, Bombay, 1985.

Rahman Muhammad Anisur, "Participatory Action Research - Theory and Practice" **Mainstream**, Vol.XXI, No.3, September 18, 1982.

Rifkin Susan B, "Health Planning and Community Participation: Case Studies in South-East Asia" Croom Helm, London/Sydney, 1985.

"Role of Non-Governmental Organisation in the Promotion of Health Care in India" Meeting of Ministers of Health of Countries of WHO South-East Asia Region, New Delhi, 25-27 September, 1984, SEA/HM Meet 4/INF 8, World Health Organisation, Regional Office for South East Asia, 17 September, 1984.

"The Role of Non-Governmental Organisations in Formulating Strategies for Health for All by the year 2000" A Position Paper Elaborated by the Non Governmental Organisation Group on Primary Health Care, Christian Medical Commission, World Council of Churches, Geneva, 1981.

"Role of Voluntary Agencies in Health Care" Theme issue of **Health Administrator,** Bangalore, Vol.2, Number 1, December, 1984.

"The Role of Voluntary Organisations in National Family Planning Programmes" Economic and Social Commission for Asia and the Far East, United Nations, Bangkok, 1972.

Roy Bunker, "For Prime Minister, A Word of Advice" **Mainstream,** Vol.XXIII, No.28, March 9, 1985.

Roy Bunker, "How Voluntary Agencies can help West Bengal" **Indian Express,** Bombay, August, 22, 1984.

Roy Bunker, "Keeping Voluntary Agencies Clean" **The Statesman** Calcutta, 11 March, 1985.

Roy Bunker, "Voluntarism and the 7th Plan" **Indian Express,** Bombay, 17 August, 1984.

"Rural Development Programme: Participation of Industrial/Business Houses" Ministry of Agriculture and Irrigation, Government of India, New Delhi, 1979.

"Sardar Nivedan" (A memorandum) to the Council of Ministers and all Congress (I) MLAs in Maharashtra Assembly, Sankramak va Viklang Kushtha Sangharsh Samiti, Tapovan, Amravati, 1983 (Marathi).

Sagar Kripa, "Health and Family Planning" Paper presented at the Seminar on the Role of Voluntary Sector in Social Services, Vigyan Bhavan, New Delhi, June 23-24, 1983, Published by - The Central Social Welfare Board, New Delhi.

Sahni Ashok (Ed) "Financing of Health Services in India" Proceedings of the Fifth Annual Conference December 13 to 15, 1984, held at New Delhi, Indian Society of Health Administrators, Bangalore, 1985.

Sethi D P, Siwal B R, "All India Directory of Voluntary Agencies in Rural Development" National Institute of Public Cooperation and Child Development, New Delhi, 1981.

Sethi Harsh, "Groups in a New Politics of Transformation" **Economic and Political Weekly,** Vol.XIX, No.7 February 18, 1984.

Sethi Harsh with Kothari Smitu (Ed), "The Non-Party Political Process: Uncertain Alternatives" UNRISD/ Lokayan, New Delhi, 1983.

Sethi I D, "Child Care and Development Strategy" **Mainstream,** Vol.XX No:26, February 27, 1982.

"Seventh Five Year Plan, 1985-90" Vol.I and Vol.II, Planning Commission, Government of India, New Delhi, 1985.

"Seventh Five Year Plan, 1985-90 and Annual Plan, 1985-86 (Part One)", Planning Department, Government of Maharashtra, Bombay, 1985.

"Seventh Five Year Plan, 1985-90 and Annual Plan, 1985-86, Maharashtra State, (Part two)" Planning Department, Government of Maharashtra, 1985.

Sharma J C "Socio-health Profile of a Rural Area: A Benchmark Study of the Rural Area Developed under 3R Society's Experimental Health Care Programme" Tata Institute of Social Sciences, Bombay, 1975.

Sheth D L, "Grass-roots Initiatives in India" Economic and Political Weekly, Vol.XIX No.6, February 11, 1984.

Shivakumar M S, "Voluntary Agencies and Development" **Mainstream,** Vol.XXIII, No.43, June 22, 1985.

Silas Rev. John, "Help - A Directory of Services for those in Need in Bombay" Parish of All Saints Church, Bombay, 1982.

Singh Chander Uday, "Baba Amte The Healing Touch" **India Today,** Special Feature, May 16-31, 1981.

Singh Tarlok, "Food Aid and Development" **Mainstream,** Vol.XXII, No:26, February 25, 1984.

Singh Tarlok, "Policy for Poverty Concentration Areas" **Mainstream,** Vol.XXII, No:8, October 22, 1983.

"Sixth Five Year Plan, 1980-85" Planning Commission, Government of India, New Delhi, 1981.

Sridharan K V "Agencies Reaching Youth in India" Vishva Yuvak Kendra, New Delhi, 1981.

"Standard of Living of the Indian People" Economic Intelligence Service, Centre for Monitoring Indian Economy, Bombay, February 1984.

Tandon Rajesh, "Voluntary Agencies-Management Perspective" **Economic Times,** Bombay, 24 October, 1978.

Taylor Carl E, Sarma R S S, Parker Robert L, Reinke William A, "Integration of Family Planning and Health Services: The Narangwal Experience" World Bank, 1980.

Teveedire Albert, "The Role of Voluntary Agencies in Building a New World Community" ACFOA Research and Information Service, Australian Council for Overseas Aid, December, 1981.

Thapar Romesh, "Where are the Organisations?" **The Illustrated Weekly of India,** Bombay, February 26, 1984.

Thapar S D, "Rural Poverty and Voluntary Action" **Mainstream,** Vol.XXI, No:51, August 20, 1983.

Thomas Harford, "A Picture of Poverty - The 1979 Oxfam Report" Oxfam, Oxford, 1979.

Vishwanath L S, "People's Organisations for Rural Development" **Mainstream,** Vol.XXIII, No.48, July 27, 1985.

"Voluntary Hospital Directory of India - 1974" The Catholic Hospital Association of India, New Delhi.

Weekes-Vagliani, Winifred, "The Integration of Women in Development Projects" Development Centre of the Organisation for Economic Cooperation and Development, Paris, 1985.

"WHO's Collaborative Activities with Nongovernmental Organisations in Official Relations" World Health Organisation, Geneva, 1985.

"Working Against Hunger - Ford Foundation Grants in Agriculture", Ford Foundation, New York, 1978.

## ABOUT FRCH

The Foundation for Research in Community Health (FRCH) is a non-governmental organisation (NGO) registered in 1975 under the Bombay Public Trust Act to carry out research in health care, with a special importance to the cultural, social and economic factors.

The FRCH has carried out research both at the conceptual level and in the field. Over the years this Foundation, as a result of its research, has influenced health policy decisions and programmes at the Central as well as at the State levels, as also in the devising and implementation of alternative strategies for health care, especially to the disadvantaged who live in the rural areas.

Action oriented field studies conducted by the FRCH have demonstrated the feasibility of implementing an alternative model for the delivery of health care based within the community, and highlighted the problems associated with it at the grass root level.

In other field studies, FRCH has critically looked at issues such as primary health care both rural and urban involvement of the NGO sector in health and development programmes, issues pertaining to the social aspects of leprosy, issues on drug policy and the pharmaceutical industry.

FRCH has brought together both medical and non-medical scientists from fields like anthropology, sociology and economics to carry out these studies.

FRCH has a library on health and related issues as well as an active documentation cell that is being used by various individuals and agencies who are interested in this field. The subjects include community and public health, mother and child health, medical and health training, women's issues, demography and birth control, sociology, economics, medicine, medical and health research, nutrition, rural development, environment issues, communicable disease, NGO projects, health planning and policy making, health education, non-allopathic systems, and WHO and World Bank documents, among others. The Foundation also receives more than 70 journals on health and related issues.

FRCH has also brought out occassional publications on various health issues.

## SELECTED FRCH PUBLICATIONS

1. The Historical Development of Health Services in India; Ms. Srilatha Batliwala, 1978.
2. Achievements and Failures in Health Care : An Analysis; Dr. N.H. Antia, 1979.
3. A New Plan for Health Care; Dr. N.H. Antia, 1979.
4. The Social Relevance of Medical Science; Dr. N.H. Antia, 1980.
5. Dilemma of Health Care; Dr. N.H. Antia, 1980.
6. Greater Bombay Statistical Information, 1980.
7. Health Care and Associated Aspects of Education : An Analysis; Dr. N.H. Antia, 1980.
8. Our Story 1975-1980, Ms. Srilatha Batliwala, 1981.
9. Problems in Primary Health and An Alternate Strategy; Dr. N.H. Antia, 1981.
10. Rural Energy Scarcity and Nutrition : A New Perspective; Ms. Srilatha Batliwala, 1981.
11. Health for All-An Alternative Strategy, Report of a Study Group set up jointly by the ICSSR and the ICMR, 1981.
12. Environment and Health; Ravi Duggal, 1982.
13. Work Place Environment; Ravi Duggal, 1982.
15. The Role of Medical Profession in Health Care; Dr. N.H. Antia, 1982.
16. Directory of Community Health Projects in India; Indira Kotwal, 1982.
17. Mandwa Story, 1982.
18. Women in Poverty : The Energy, Health and Nutrition Syndrome; Ms. Srilatha Batliwala, 1983.
19. Education for Health; Dr. N.H. Antia, 1984.
20. Women & Health : A Critical Review of Available Information in India; Ms. Mona Daswani/ Mr. G.A.A. Britto, 1984.
21. A Visit to China; Dr. N.H. Antia, 1984.
22. Peoples' Health in Peoples' Hands : A Plea for A Peoples' Health Movement (Based on the ICMR/ ICSSR report Health for all : An Alternative Strategy): Dr. N.H. Antia, 1984.
23. Health and Population in Three Tribal Villages of Dhule District, Maharashtra; Ravi Duggal, 1984.
24. Hospitals or Health Care ?; Dr. N.H. Antia, 1985.
25. Plea for a People's Health Movement; Dr. N.H. Antia, 1985.
26. Leprosy Control by a People's Programme, 'A New Concept in Technology Transfer', Dr. N.H. Antia, 1985.



Xerox by I. B. C. S. 38, Police Court Lane, Fort, Bombay - 400 001. Phone : 260726